

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar MRI

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines and Treatment Guidelines

Utilization review dated 09/14/11, non-certification, lumbar MRI

Utilization review dated 10/7/11, non-certification appeal request, lumbar MRI

IRO response dated 10-10-11

Initial report and follow-up note, DC, dated 08/08/11 and 09/02/11

Encounter notes, MD, dated 6/28/11 through 7/20/11

Peer review report, DC, dated 08/12/11

Pre-authorization adverse determination lumbar MRI dated 0/8/18/11

Physician review recommendation dated 07/25/11, adverse determination lumbar MRI spine without contrast

Neurologic electrodiagnostic exams MD, dated 10/06/11

Musculoskeletal diagnostic ultrasound, MD, dated 10/06/11

Utilization review dated 08/16/11, non-certification physical therapy

MRI, right knee, dated 08/16/11

X-rays, left shoulder, dated 08/16/11

Right knee radiographs dated 08/20/11

PATIENT CLINICAL HISTORY SUMMARY

This a female who was injured on xx/xx/xx, when she slipped and fell on a wet floor. She fell down, did a split and hit her inner knee and lower back against the floor. She felt an immediate tenderness at her lower back, right knee, and right ankle joints. She also used her left hand to break her fall and noticed an increase in tenderness at her left shoulder. Initial treatment included x-rays of the right knee. She was given naproxen, Flexeril, and amitriptyline. Electrodiagnostic testing on 10/06/11 reported findings consistent with bilateral tarsal tunnel syndrome; left peroneal axonopathy; findings suggestive of relative right L4 radiculopathy. Musculoskeletal diagnostic ultrasound performed 10/06/11 reported findings within normal limits. The claimant was recommended to undergo MRI of the lumbar spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The claimant was noted to have signs and symptoms of radiculopathy, with EMG findings suggestive of a relative right L4 radiculopathy. However, there was no indication that the claimant had had a trial of conservative treatment including physical therapy or other conservative care. There also is no indication that she had plain radiographs of the lumbar spine performed. As noted on previous review, the claimant had no evidence of seat belt (chance) fracture, red flags, cauda equina syndrome, or myelopathy. Per Official Disability Guidelines, MRI may be indicated for uncomplicated low back pain with radiculopathy after at least one month conservative therapy, sooner if severe or progressive neurological deficit. Given the current clinical data, the request for the proposed lumbar MRI does not meet Official Disability Guidelines criteria for medical necessity.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)