

# Parker Healthcare Management Organization, Inc.

3719 N. Beltline Rd Irving, TX 75038

972.906.0603 972.255.9712 (fax)

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## Notice of Independent Review Decision

**DATE OF REVIEW:** OCTOBER 12, 2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed Lumbar MRI (72148)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

**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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10/724.4	72148		Prosp	1			xx/xx/xxxx		Upheld

-Request for an IRO- 20 pages

Respondent records- a total of 23 pages of records received to include but not limited to: Notice of an IRO; TDI letter 9.22.11; 8.25.11, 8.1.11; records DR 7.27.10-7.26.11

Requestor records- a total of 51 pages of records received to include but not limited to:

Notice of an IRO; TDI letter 9.22.11; records DR 7.27.10-9.20.11; Study 8.9.10; CT Myelogram 9.16.10; MRI Lumbar 7.21.10; Request for an IRO forms; 8.25.11, 8.1.11; Medical Clinic records 6.28.10-12.6.10;

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a work related on the job injury on xx/xx/xxxx.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The denial is upheld. Using O D G guidelines, a repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg tumor, infection, fracture, neurocompression, and/or recurrent disc herniation).

According to the records, the patient has had a recurrence of symptoms. The prior MRI demonstrated findings which would explain the symptoms. It does not appear, based on this information, that anything new, in terms of treatment options, would be determined by repeating the procedure.

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

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES