

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 09/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat lumbar MRI

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the repeat lumbar MRI is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/01/11
- Denial letter – 07/29/11, 08/03/11
- Prospective Review– 09/01/11
- Email– 08/30/11
- Email– 08/30/11

- Decision notice for Pre-authorization – 07/26/11
- Email– 07/26/11
- Order for MRI from Dr. – 07/25/11
- Patient profile by Dr.– no date
- Summary of Disputes– no dates
- Patient profile by Dr. – no date
- Report of MRI of the lumbar spine – 08/06/07, 09/15/08, 09/21/10
- Operative note and discharge summary by Dr. – 11/20/08
- History and Physical by Dr. – 12/22/08
- Office visit notes by Dr. – 11/03/10
- Office visit notes by Dr. – 07/20/11
- Office visit notes with diagnostic testing by Dr. – 09/18/08
- Office visit notes by Dr. – 12/04/08, 07/25/11, 08/04/11
- Surgery orders by Dr. – 12/05/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xxxx when he was working using a machine and felt a sharp pain in his lower back when he pulled the machine out. He was diagnosed with a herniated lumbar disc at L5-S1 and underwent a microdiscectomy in March of 09. The patient is has had pain in his low back and radiating sometimes to both legs and sometimes just to his left leg. He has been treated with epidural steroid injections, physical therapy and medications and there is a request for a repeat MRI of the lumbar spine.

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

This patient has two MRIs of his low back showing that he has degenerative changes and arthritic changes of L4-L5 and L5-S1 as well as a herniated disc at L5-S1 to the left. The patient's follow up MRI showed that he has some fibrosis but no additional herniation and this was after the surgery. The patient now complains about pain more in his right leg; however, his physical examination shows no radiating signs, no evidence of weakness, no evidence of numbness or tingling, and no reflex changes in the right lower extremity. There is symptomatology of the leg pain but no supporting objective findings. Since the patient has no signs of any radiculopathy such as with reflex changes, weakness, or atrophy, this patient does not meet the ODG guidelines for a new MRI.

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

- ACOEM- AMERICAN 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)