

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: September 2, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI of the Lumbar Spine with and without contrast. CPT Code: 72158.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- General Hospital, 01/11/01,
- DWC-69, Report of Medical Evaluation, 08/31/01,
- D.C., 08/30/01,
- Memorial Hospital, 01/24/02, 05/02/02,
- Medical Center, 11/23/02,
- M.D, 03/06/03, 11/20/09, 03/19/10, 06/21/10, 09/22/10, 12/22/10, 03/22/11, 06/20/11, 07/19/11,
- Insurance Company, 06/29/11, 08/01/11, 08/25/11

Medical records from the Provider include:

- Medical Center, 11/23/02
- M.D., 07/18/05, 09/12/05, 10/12/05, 11/07/05, 12/07/05, 01/11/06, 02/13/06, 02/27/06, 03/31/06, 04/27/06, 05/17/06, 06/21/06, 07/25/06, 09/25/06, 12/22/06, 03/21/07, 06/25/07, 10/03/07,

01/04/08, 04/04/08, 07/07/08, 07/22/08, 08/13/08, 08/29/08, 11/26/08, 02/25/09, 05/22/09, 08/21/09, 11/20/09, 03/19/10, 06/21/10, 09/22/10, 07/19/11

PATIENT CLINICAL HISTORY:

To Whom It May Concern:

I have had the opportunity to review medical records on this patient. The records indicate a date of injury of xx/xx/xxxx, and include a report of injury to the lumbar spine. The records indicate that in 1999 he developed lower back pain.

An MRI disclosed an L5-S1 disc herniation, and the patient was referred to M.D.

The patient underwent endoscopic discectomy at L5-S1 on January 11, 2001. He did not do particular well following the surgery and eventually had a posterolateral fusion from L5 to S1. Physical therapy was prescribed.

The patient had continued symptoms and a third surgical procedure was performed in 2003. This included an L3-4 endoscopic discectomy and L4-5 endoscopic discectomy. This was also performed by Dr.

There was a gap in treatment between 2003 and 2009. The patient returned to Dr. with ongoing complaints of back pain radiating down his leg. The patient had been placed on medications for an extended period of time, including narcotics, muscle relaxants, and anti-inflammatories.

Dr. ordered an MRI on August 25, 2011. This was declined by the carrier. It was appealed and again declined by the carrier. The denial provided by M.D., indicated the patient had not undergone an evidence-based physical therapy program.

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

An Independent Review Organization (IRO) was requested. The MRI denial should be overturned. The ODG does not require physical therapy as a guideline in repeat MRI. A significant change in pathology, symptoms and/or physical findings suggestive of a change in medical condition is provided. I noted from the most recent note by Dr. Urea that there were diminished reflexes and weakness. This was a significant change from his previous physical examination, and therefore, the non-certification should be overturned.

I trust that this will be sufficient for your needs.

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)