

**AccuReview**  
An Independent Review Organization  
(903) 749-4271 (phone)  
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Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 28, 2011

**IRO CASE #:**

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

Lumbar MRI

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

This physician is Board Certified Orthopedic Surgeon with over 40 years of experience.

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

8/1/08: MRI of Lumbar Spine was performed.

5/3/11: D.C. evaluated the claimant. PE: Motor Exam was 5/5. SLR was positive at 45 degrees on the left and 60 degrees on the right. Impression: Radiculitis, Lumbar Sprain/Strain, and SI sprain/strain.

6/8/11: D.C. re-evaluated the claimant. PE: Is unchanged.

6/9/11: M.D. performed a Lumbar Myelogram on the claimant.

6/29/11: D.C. evaluated the claimant. PE: Motor Exam was 5/5. SLR was positive at 25 degrees on the left and 20 degrees on the right.

7/12/11: M.D. evaluated the claimant. PE: He has full ROM of the lumbar spine. He has some tenderness to the paraspinal muscles and gluteal region.

7/20/11: D.O. performed an UR on the claimant. Rationale for Denial: Repeat MRI is not routinely recommended and should be reserved for claimant with significant change in symptoms and/or findings suggestive of significant pathology. Most recent examination revealed no evidence of motor, sensory, or reflex changes .

7/21/11: D.C. completed a Letter of Reconsideration.

7/27/11: M.D. performed an UR on the claimant. Rationale for Denial: There are no serial office notes documenting progressive neurologic deficit.

8/3/11: D.C. completed a Letter of Reconsideration.

#### **PATIENT CLINICAL HISTORY:**

The claimant was injured on xx/xx/xxxx.

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

The previous decisions are upheld. Per the medical records provided the claimant had normal sensory and motor examinations. Furthermore there is no documentation of change in the claimant's condition in the provided medical records. Based on the above-mentioned the claimant does not meet the criteria for a Repeat Lumbar MRI per the ODG.

#### **PER THE ODG:**

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, recurrent disc herniation). ([Bigos, 1999](#)) ([Mullin, 2000](#)) ([ACR, 2000](#)) ([AAN, 1994](#)) ([Aetna, 2004](#)) ([Airaksinen, 2006](#)) ([Chou, 2007](#))

**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)