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**Notice of Independent Review Decision
Reviewer's Report**

DATE OF REVIEW: JULY 20, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI; Lumbar without contrast (CPT 72148).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested service, MRI; Lumbar without contrast (CPT 72148), is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 6/27/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/2/12.
3. Notice of Assignment of Independent Review Organization dated 7/2/12.
4. Pre-Authorization Request for MRI from Chiropractic and Wellness Center dated 6/14/12.
5. Chiropractic and Wellness Center clinic notes dated 6/14/12.
6. Fax Pre-Certification Requests from Chiropractic and Wellness Center dated 6/21/12 and 6/14/12.
7. Denial documentation dated 6/26/12 and 6/20/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. Clinic notes dated 6/14/12 reported the patient complained of low back symptoms from trying to do some weed-eating at home. The patient rated the low back pain at 6 of 10. The notes further indicate that chiropractic therapy and stretching improved the patient's symptoms. Physical examination revealed motion-palpable

fixation, muscle spasms, subluxation at left T3, T7, T11, L4, and right L5 and S1 of mild intensity. The patient was treated with adjustments and recommended for magnetic resonance imaging (MRI) of the lumbar spine. The patient's request for the MRI was denied as not medically necessary due to the absence of any neurologic deficit.

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

Consistent with the recommendations in the Official Disability Guidelines (ODG), the requested MRI of the lumbar spine is not medically necessary for evaluation and/or treatment of this patient's medical condition. The records document the patient's complaints to include low back pain. However, there was no indication that the patient's low back pain was radiating into the lower extremities. In addition, the physical examination did not reveal any evidence of neurological deficits to warrant an MRI of the lumbar spine. Further, there was no discussion of previous non-diagnostic plain film radiographs of the lumbar spine. Therefore, the requested MRI of the lumbar spine is not medically indicated at this time.

Given the lack of neurological deficits, the requested MRI; Lumbar without contrast (CPT 72148) is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)