

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/06/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient Lumbar MRI

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

Board Certified PM&R and Pain 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Multiple prescription requests and worker's compensation work status reports
Employer's first report of injury or illness
Clinic notes DO 01/04/10-07/12/12
MRI lumbar spine without contrast dated 01/22/10
Initial office consultation and follow-up notes M.D. 02/24/10
Notice of disputed issues and refusal to pay benefits
Notice of intent to issue an adverse determination dated 03/31/10
Notice of utilization review findings dated 04/15/10
Notice of utilization review findings dated 05/21/10
Notice of administrative denial 05/27/10
Report of medical evaluation dated 07/30/10
Letter from Texas Department of Transportation dated 08/04/10 and 10/04/10
Letter Dr. dated 08/27/10
Letters from Texas Department of Insurance DWC 09/01/10-03/02/11
MRI lumbar spine with contrast 09/17/10
Designated doctor's evaluation / RME dated 10/15/10
Letters office of injured employee counsel 11/01/10, 11/02/10, 11/24/10
MRI brain without contrast dated 11/14/10
MRI cervical spine without contrast dated 11/14/10
MRI thoracic spine without contrast dated 11/14/10
Peer review report 12/15/10
Request for designated doctor's evaluation 01/24/11
Designated doctor's evaluation 03/31/11
Letter of clarification dated 04/26/11
Designated doctor's evaluation addendum dated 04/27/11
Questions to be asked on hearing 04/19/12 for
Claimants exhibit list

Court Docket 04/26/12

Notice of intent to issue an adverse determination 06/20/12

Notice of utilization review findings dated 07/02/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a lifting injury to the low back on xx/xx/xx while working. He complains of low back pain radiating to the left greater than right lower extremity. MRI of the lumbar spine on 01/22/10 revealed multiple levels of degenerative disc disease with broad based disc bulges at L2-3, L3-4, and L4-5. There was no significant stenosis at the L2-3 level. At L3-4 and L4-5 there was moderate to severe central canal stenosis as well as varying degrees of bilateral foraminal narrowing. There was a questionable nodular lesion seen to involve the cauda equina posterior to the body of L2. Repeat MRI of the lumbar spine on 09/17/10 reported small nodular enhancement seen to involve the cauda equina at the L2-3 level. Enhancement was seen in the cauda equina at the L3-4 level likely related to radiculitis due to severe stenosis at this level. Claimant continued to complain of low back pain and left lower extremity radicular pain. He failed to respond to conservative care. A decision and order dated 04/23/12 following contested case hearing determined that the compensable injury extends to include an aggravation of the claimant's degenerative disc disease, degenerative facet disease and lumbar spinal stenosis at L3-4, L4-5 and L5-S1. It was further determined that the claimant has not reached maximum medical improvement.

A request for outpatient lumbar MRI was non-authorized per utilization review dated 06/21/12 noting that the request does not meet Official Disability Guidelines criteria and that the clinical provided does not demonstrate a progression of neurological deficit.

A reconsideration request for outpatient lumbar MRI was denied per utilization review dated 07/02/12 noting that the request does not satisfy Official Disability Guidelines which requires low back pain with associated neurological deterioration. The claimant reportedly complains of increased lower extremity pseudo-claudication symptoms without documented associated change in lower extremity neurological examination.

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

Based on the clinical information provided, the request for repeat lumbar MRI is indicated as medically necessary. The claimant sustained a lifting injury to the low back on xx/xx/xx. Previous MRI was noted to show spinal stenosis at multiple levels, claimant has failed to improve with conservative care including activity modification, medication and injections. It's noted that the claimant's symptoms are worsening. He is considered a surgical candidate and repeat MRI is warranted for surgical planning. As such previous denials are overturned.

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

- ACOEM-AMERICA 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)