



14785 Preston Rd. Suite # 550 | Dallas, Texas 75254
 Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision
 Amended and Sent on 12/11/2012

DATE OF REVIEW: 11/26/2012

Date of Amended Decision: 12/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient MRI of the Lumbar Spine without Contrast

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

M.D. Board Certified in Occupational Medicine and Urgent Care.

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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	11/06/2012
Notice of Utilization Review Findings	10/24/2012-10/31/2012
Request for Pre-Authorization	10/25/2012
MD's Notes	9/04/2012-10/17/2012
Operative Report	10/10/2012
Operative Report Radiography Note	11/04/2012 11/14/2012
MRI Report	1/15/2008

PATIENT CLINICAL HISTORY [SUMMARY]:



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The claimant has chronic low back pain reportedly associated with injury of xx/xx/xx. Thus far, he has been treated with the following: Analgesic medications; unspecified number of prior lumbar facet injections; adjuvant medications; an MRI of the sacroiliac joints of November 15, 2008, notable for low-grade facet arthritis and a broad-based disk protrusion at L5-S1; MRI of the lumbar spine of November 15, 2008, also notable for a low-grade disk bulge/herniation at L5-S1, and other mild low-grade disk herniation. The most recent progress note of October 17, 2012, is notable for comments that the claimant had underwent recent facet joint injections without any relief, is on Advil for pain relief, is uncomfortable, exhibits a balanced gait, limited range of motion, positive right-sided straight leg raising, well-preserved lower extremity sensorium and reflexes, and treatment recommendations which include continued usage of tramadol and Phenergan for pain relief while pursuing a repeat lumbar MRI. It is incidentally noted that a prior note of September 10, 2012, is notable for comments that the claimant exhibits weight loss of more than 10 pounds over the preceding year.

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

The requested outpatient MRI of lumbar Spine without contrast is medically necessary.

The claimant has seemingly had a prolonged duration of symptoms. The symptoms of low back pain have persisted for quite sometimes. While the attending provider has not clearly proffered a deferential diagnosis, there is some incidental mention made of weight loss, calling into question a possible neoplastic source for the claimant's symptoms. It is further suggested that the claimant is missing substantial amounts of time from work. There does, thus, appear to have been progressive worsening in the clinical picture since September 2012 that has not resolved with time.

MRI imaging may therefore be appropriate here. The original utilization review decisions are overturned. The proposed lumbar spine MRI without contrast is hereby certified.



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**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)

<http://www.acr.org/~media/ACR/Documents/AppCriteria/Diagnostic/LowBackPain.pdf>

American College of Radiology , ACR Appropriateness Criteria

“Clinical Condition: Low Back Pain Indications of a more complicated status include back pain/radiculopathy in the following settings [14-15]: