

# IRO Express Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Nov/28/2012

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the lumbar spine

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

Board Certified Orthopedic Surgery

### 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

Clinical notes 01/26/12 and 09/21/12

Physical therapy report 06/04/12

Clinical notes 03/30/12-10/29/12

Electrodiagnostic studies 04/03/12

Operative report 04/16/12

Prior reviews 10/11/12 and 11/05/12

Cover sheet and working documents

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury to the left upper extremity on xx/xx/xx lifting. The patient was followed for complaints of left shoulder pain and electrodiagnostic studies on 04/03/12 revealed no clear evidence of upper extremity radiculopathy or ulnar neuropathy. This study recommended MRI studies of the cervical spine. The patient underwent left shoulder arthroscopy with distal claviclectomy and acromioplasty on 04/16/12. The patient also underwent post-operative physical therapy. The patient was referred for work conditioning in 08/12 and underwent a left subacromial bursal injection on 08/14/12. The patient was seen on 10/01/12 with complaints of low back pain. The patient denied any prior history of low back pain and medications at this visit included tramadol and hydrocodone. Physical examination revealed no evidence of neurological deficits and there was tenderness to palpation in the lower lumbar spine. The patient was recommended for MRI study of the lumbar spine at this visit. Follow up on 10/29/12 stated that the patient continued to have

complaints of low back pain. The patient denied any radiating pain to the lower extremities. Physical examination again revealed no evidence of neurological deficits. The request for MRI of the lumbar spine was denied by utilization review on 10/11/12 as there was no evidence of red flags that would support advanced imaging studies including MRI of the lumbar spine. The request was again denied by utilization review on 11/05/12 as there was no evidence of neurological deficits.

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

The requested MRI of the lumbar spine would not be supported as medically necessary based on the clinical documentation provided for review and current beg. The patient began to have complaints of low back pain in November or October of 2012, however. The patient denied any radiating pain to the lower extremity or into the lower extremities. Physical examination findings revealed no evidence of focal neurological focal or progressive neurological deficits in the lower extremities that would reasonably support MRI studies for the lumbar spine as outlined by guidelines. There is also no indication that the patient has received any conservative treatment for his low back complaints including physical therapy or anti-inflammatories. As the clinical documentation provided for review does not meet guideline recommendations for the requested services, medical necessity would not be established at this time.

**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)