



# INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

**REVIEWER'S REPORT**

**DATE NOTICE SENT TO ALL PARTIES:** 08/27/13

**IRO CASE #:**

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

Texas-licensed M.D., board certified in Orthopedic Surgery

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

Repeat lumbar MRI

**REVIEW OUTCOME:**

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

- Upheld** (Agree)
- Overtured** (Disagree)
- Partially Overtured** (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp</i>				<i>Xx/xx/xx</i>	<i>xxxxx</i>	<i>Upheld</i>

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. TDI case assignment.
2. Letter of denial 06/20/13, 06/21/13 & 08/02/13, including criteria used in the denial.
3. Doctor's visit note 06/14/13.
4. Pre-authorization request 12/22/09.
5. MRI report – lumbar spine, 07/18/96.
6. Follow-up exam 12/22/09

**PATIENT CLINICAL HISTORY (SUMMARY):**

The injured employee is a male who complains of low back pain and chronic right leg pain of many years duration. The date of injury is xx/xx/xx. The mechanism of injury is not described. The examinee has low back pain and primarily right leg pain and tingling. He is currently being treated with pain medication including Lyrica, nonsteroidal anti-inflammatory medication including Advil, and Vempro. An MRI scan performed in xxxx revealed a large herniated nucleus pulposus at the level of L4/L5 with degenerative disc disease at other levels. Medical records are present on two clinical evaluations, neither of which documents neurological loss. A request has been submitted for repeat MRI scan. The request was denied; it was reconsidered and denied.

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

The medical records suggest that the repeat MRI scan is required to evaluate for chronic back pain and right leg pain. There is a suggestion that surgical procedure could be considered, depending on the findings of a repeat MRI scan. There is no documentation of neurological evaluation at the time of two most recent clinical evaluations in December 2009 and June 2013. In the absence of any documented neurological loss, repeat MRI scan is not indicated. The prior adverse determinations were appropriate and should be upheld.

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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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)