



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

DATE NOTICE SENT TO ALL PARTIES: 01.21.14

IRO CASE #:

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

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering low back pain problems

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI scan of the lumbar spine without contrast

REVIEW OUTCOME:

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

- X** Upheld **(Agree)**
- Overturned (Disagree)
- Partially Overturned (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>
724.3			<i>Prosp.</i>				<i>Xx/xx/xx</i>		<i>Upheld</i>

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a male who suffered a lumbar strain type of injury on xx/xx/xx. He has had low back pain and left leg pain. He has been treated with nonsteroidal anti-inflammatory medication, pain medication, physical therapy, and activity modifications. He has received a left sacroiliac joint injection. All therapy has provided only temporary improvement in symptoms. He has developed chronic pain syndrome. Physical findings have not provided proof of radiculopathy. Extensive studies, including MRI scan, CT scan, and myelogram of the lumbar spine have been negative. EMG/nerve conduction study has not provided confirmation of radiculopathy. It would appear the claimant suffers chronic myofascial pain syndrome. The current request is for preauthorization of a repeat MRI scan of the lumbosacral spines. The request to preauthorize such a diagnostic study was considered and denied. It was reconsidered and denied.

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

It would appear that this claimant suffers chronic pain syndrome. There are no physical findings or clinical studies to suggest compressive neuropathology. Prior MRI scan and CT scans, and a lumbar myelogram have been negative. EMG/nerve conduction study is essentially within normal limits, suggesting myofascial pain. There are no changes in the neurological findings that would warrant a repeat MRI scan. Prior determinations were appropriate and should be upheld.

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

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- 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)