

Notice of Independent Review Decision

March 10, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity of MRI of the Lumbar Spine without Contrast 72148

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

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 of the health care services in dispute.

Upon independent review, I find the previous adverse determination should be Upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received:

PATIENT CLINICAL HISTORY [SUMMARY]:

This female was injured xx/xx/xx working when she felt a pop in her back. Subsequently, the patient was seen who had recommended L4-5/L5-S1 fusion. The patient then started care with ongoing conservative treatment, epidural steroid injections, SI joint injections with failure to respond.

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Currently, the patient continues to complain of low back pain in the left low back and buttock area. It was noted that the patient did have a discography study that noted concordant L4-5 pain, and the patient does have a Grade 2 spondylolisthesis at L5-S1 with complete disk space collapse.

There is a current request for a repeat lumbar MRI, which has been recommended for noncertification. The recommendation for noncertification notes the records do not document a progression of subjective complaints, and there was a lack of documentation of red flag issues that would support a repeat MRI.

The most current of the two reviews were performed 01/10/14 and 02/12/14. The medical records provided for my review did not document a response to either peer review.

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

The rationale for noncertification is the prior peer review concerns are valid in that the records do not adequately document a progression/worsening of subjective complaints or red flag issues that would support the need for a repeat lumbar MRI within *ODG* recommendations. *ODG* indicates for repeat MRI there should be documentation of a progression or worsening of complaints or neurological findings, which was not noted, and red flag issues, which were not noted.

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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)