



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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## Notice of Independent Review Decision

**DATE OF REVIEW: 4/08/2015**

**IRO CASE #**

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

MRI Lumbar spine without dye.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

**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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work related back injury on xx/xx/xx. She has since undergone a lumbar spine decompression and fusion at L4-5 on 4/11/14. Back and right leg radicular symptoms persisted since the surgery. Her back pain improved some with PT but the leg symptoms did not. Per the most recent clinical notes she has some R L5 weakness that is equivalent to that documented prior to the surgery and some sensory changes consistent with her pre-op symptoms as well. There has been no reported injury or significant change in her clinical symptoms since the surgery.

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

Per ODG references, the requested services "MRI Lumbar spine without dye" is not medically necessary. Repeat MRI of the lumbar spine is not certified due to not having significant symptomatic change or deterioration since the time of surgery to suggest a new process such as tumor, infection, fracture, or recurrent disc herniation requiring MRI evaluation.



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

- 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