

# **IRO Express Inc.**

**An Independent Review Organization**

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## **Notice of Independent Review Decision**

### **Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

### **Description of the service or services in dispute:**

MRI of Spine Lumbar

**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 male who reported an injury to his low back when he fell off a roof on xx/xx/xx. The clinical note dated 08/28/14 indicates the patient having fallen 15 feet from a roof onto his buttocks. There was an indication of a loss of consciousness at the site of the injury. The patient reported no numbness or weakness in the lower extremities. The clinical note dated 09/30/14 indicates the patient reporting intermittent numbness in both lower extremities. Radiating pain was identified from the low back into both lower extremities. The patient stated the low back pain was affecting his sleep hygiene. The patient has been utilizing Zanaflex, Celebrex, and Norco for pain relief. No reflex changes were identified by exam. The patient was able to demonstrate good range of motion throughout all extremities. No strength deficits were identified. The x-rays of the lumbar spine revealed a compression fracture of the L1 vertebral body without retropulsion. Internal disc derangement of the L5-S1 disc was revealed. The clinical note dated 11/25/14 indicates the patient presenting for a follow up regarding the use of a brace to address an L1 compression fracture. The note indicates the patient continuing with the use of the brace.

The utilization reviews dated 12/04/14 & 12/11/14 resulted in denials as no information was submitted regarding the patient's confirmation of neurologic deficits.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to**

***support the decision.***

The documentation indicates the patient complaining of low back pain with radiation of pain into the lower extremities. An MRI is indicated in the lumbar region provided the patient meets specific criteria to include significant neurologic deficits associated with the lumbar region. No information was submitted regarding the patient's reflex, strength, or sensory deficits identified in the lower extremities. Without provocative testing and confirmatory evidence regarding the patient's radiculopathy in the lower extremities, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an MRI of the lumbar spine is not recommended as medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
  
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)