



IRO REVIEWER REPORT -WC

TEXAS DEPARTMENT OF INSURANCE

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DATE OF REVIEW: June 17, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Lumbar

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

The TMF physician reviewer is a licensed Family Practice physician with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that an MRI of the lumbar spine is not medically necessary to treat this patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worked sustained a back injury on xx/xx/xx while pulling on a dolly, attempting to disengage it from a truck. Evidence of neuropathy was documented and the patient underwent a laminectomy and discectomy, L4-L5 in 2013. He continues with pain and worsened with light duty (carrying storage boxes).

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

In review of the physicians' notes, no indication of progression of the initial injury or additional treatment is noted. The information submitted for review states that the Primary Care Physician wants to send the patient to a pain management clinic but is unable to do so without a current MRI. This is unreasonable since the pain management physician would evaluate the patient and decide for himself/herself what testing would be necessary. Since there is no information to indicate progression of problems and no additional conservative treatment, as per Workers' Compensation Guidelines, the MRI at this point would not be indicated.

**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)

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