

Applied Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 3/31/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI Thoracic and Lumbar Spine

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

M.D., Board Certified in Occupational 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)

Upon independent review the reviewer finds that the requested MRI of Thoracic and Lumbar Spine is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/13/08, 2/27/08
ODG Guidelines and Treatment Guidelines, Low Back
Vitals 3/4/08, 10/8/07, 8/10/07
Notes 3/4/08, 2/1/08, 1/2/08, 12/3/07, 11/5/07, 10/18/07, 8/10/07, 9/10/07
Letter 10/8/07
MRI Report 6/21/04
Spine and Hip X-Ray Reports 7/19/04
Appeal Letter 2/19/08
Imaging Requisition
Response Letter 3/12/08
TWCC Report 2/22/05
DC 2/9/05

Revised Questionnaire
Daily Living History
Pain Drawing
Pain Questionnaire
Pain Scale
Job Analysis
Scale
MRI Report 2/21/03
Treatment History

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient suffered an injury. The MRI report from 6/21/04 demonstrated a broad based central annular bulge at L5-S1. The patient returned to work without restrictions. The treating doctor has requested repeat MRI for thoracic and lumbar spine. This was requested because the patient transferred to a different treating physician and the new physician is interested in seeing if there have been "any changes". There was no information available in the medical record regarding new symptoms or clinical exam findings.

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

Upon review of the provided records the reviewer finds that the requested MRI of the thoracic and lumbar spine is not medically necessary. The request does not meet the criteria set forth in the ODG guidelines.

The ODG 2008, Low Back Chapter, MRI indicates that repeat MRI's are only indicated in cases with progression of neurologic deficit. This has not been demonstrated in this case.

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)**