

# True Resolutions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** SEPTEMBER 17, 2008

**IRO CASE #:**

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

Outpatient MRI of Lumbar Spine

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

Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic Surgery

## **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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 8/19/08 and 8/11/08  
Records from 3/16/05 thru 8/6/08; Radiology report 8/4/08  
OP Report 4/5/07  
Records from Dr. 8/8/07 and 1/31/08  
Letters from 6/20/08 and 6/10/08  
Records from Pain & Health Management 6/6/07 thru 5/28/08  
Record from Dr. 7/20/04  
Records from Dr. 1/9/04 thru 6/7/06

Bone Scan 8/30/06  
Records from Bone & Joint 5/18/00 thru 6/6/07  
Psych Eval 12/21/00  
Record from 4/12/02

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient has undergone a successful 360 degree L4-S1 spinal fusion. She recently developed progressive leg paresthasias requiring narcotics. An enhanced MRI scan has been denied by the insurance company as medically unnecessary.

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

The requested study would be appropriate for this patient. She has developed new neurologic symptoms and these certainly could represent junctional disease. As such, the request is medically reasonable and necessary.

**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)**