

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, ME 04915

Phone: (512) 782-4560

Fax: (207) 470-1035

Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Magnetic Resonance (EG, Proton) Imaging, Spinal Canal and contents, Lumbar; without contrast material

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

M.D., board certified in Orthopedic 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

1. Adverse Determination letters, 05/22/09, 06/11/09
2. Dr., 06/29/09, 06/01/09, 05/04/09, 04/06/09, 02/05/09, 01/08/09, 12/11/08, 11/13/08, 10/15/08, 08/21/08, 07/24/08, 06/30/08, 06/26/08, 05/28/08, 05/22/08, 04/14/08, 04/24/08, 03/27/08
3. CT scan of lumbar spine, 05/23/03, 09/16/02
4. MRI scan of lumbar spine, 06/25/01
5. X-ray of lumbar spine, 02/07/02
6. ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who currently is xx years of age. She has undergone a previous lumbar fusion. She has a previous spinal cord stimulator in place based on the imaging studies provided. There is no medical record documenting if it has been removed in the interim. She is on a plethora of pain and psychotropic medications. Current request is for imaging of an MRI scan without contrast.

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

Under the ODG Guidelines, in order to be qualified for a repeat imaging study, the patient would have needed to have shown progressive neurologic deficit. There is no evidence of

such within the medical record. In addition, the request for repeat MRI scan without gadolinium in the face of previous surgery does not conform to recommended guidelines. The reviewer finds that medical necessity does not exist for Magnetic Resonance (EG, Proton) Imaging, Spinal Canal and contents, Lumbar; without contrast material.

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

- ACOEM-AMERICA 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)