

SENT VIA EMAIL OR FAX ON  
Jun/08/2009

## Pure Resolutions Inc.

An Independent Review Organization  
1124 N Fielder Rd, #179  
Arlington, TX 76012  
Phone: (817) 349-6420  
Fax: (512) 597-0650  
Email: manager@pureresolutions.com

**DATE OF REVIEW:**  
Jun/08/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Repeat lumbar MRI

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
Board Certified Orthopedic Surgeon

**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  
MRI L/S, 03/02/04  
Designated doctor exam, 01/29/09  
Office note, Dr., 04/07/09  
Peer review, 04/15/09, 04/24/09  
Request for reconsideration, Dr. 04/20/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male with a diagnosis of lumbar discogenic pain related to a date of injury was on xx-xx-xx. The claimant has had constant lower back pain. An MRI on 03/02/04 revealed minimal retrolisthesis of L5-S1, mild disc height loss at L4-5, annular disc bulge at L4-5, L5-S1, left foraminal stenosis and minimal left lateral annular disc bulge at L3-4. He was seen by Dr. for a designated doctor exam where it was noted that the claimant had been treated conservatively in the past with physical therapy, caudal, lumbar and sacral selective epidurals injections, and medications. On 04/07/09, the claimant continued to complain of severe low back pain and an X-ray showed mild narrowing L4-5 and degenerative changes with spur formation on right. Dr. has requested a repeat MRI since last test was in 2004.

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

The request is for repeat MRI. The claimant has a history of chronic back pain. There has been basically no change in his condition. He continues to complain of back pain. However, there is no history of recent trauma, a new event, or progressive radicular symptoms. Thus,

there is no justification for an MRI. His condition appears to be rather stable and he is only bothered by back pain. There are no reported constitutional symptoms or change in his medical condition otherwise.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates – low back

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)