

SENT VIA EMAIL OR FAX ON
Aug/09/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI with and without contrast for the lumbar

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

Board Certified in Physical Medicine and Rehabilitation

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 7/7/10 and 7/22/10
Dr. 7/4/04 thru 6/16/10
Lumbar Spine 6/21/07
X-Ray 11/3/06
MRI 5/4/07
CT Post Diskcogram 7/29/04
7/18/07 thru 4/2/10
MRI 3/16/10
7/21/10
Medications 3/28/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured on xx/xx/xx. He subsequently under went 3 operations including discectomies and a fusion at L4/5. He is diabetic and surgery had been delayed for medical reasons per Dr.. MRIs in 2007 showed a right HNP. An undated EMG by Dr., apparently from other notes, showed a left L5 radiculopathy in 2007. The fusion followed. He has had ESIs and a dorsal column stimulator. The examinations in 2/10 described new symptoms on the right side with weak dorsiflexion and positive SLR. The MRI (3/16/10) showed post op changes and a possible disc extrusion into the foramen. The radiologist was not clear if it could also be scar tissue. He commented about the role for a repeat study with contrast if there were any new neurological findings in that myotome/dermatome.

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

The multiple notes after the MRI did not describe any new neurological loss. There were no further comments of any radicular pain pattern or motor loss beyond the initial assessment of the right sensory complaints. The ODG does approve an MRI after symptoms develop after surgery. That was the justification of the MRI in March. Although the radiologist noted that a repeat MRI with contrast should be considered, the doctor advised based upon neurological findings. No additional findings were described to justify the repeat MRI with contrast.

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)