

SENT VIA EMAIL OR FAX ON
Aug/02/2010

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

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient MRI of the lumbar spine with contrast

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 6/16/10 and 7/5/10 , Healthcare Clinic 3/17/10 thru 6/28/10, MRIs 2/12/10 and 8/28/08, Ortho 8/21/08 thru 2/16/10, Spine Associates 4/13/10 thru 5/1/10, Pain Management 12/10/09 thru 6/15/10, Dr. 1/19/09 , Dr. 6/9/09 thru 1/5/10, 251 pages from 10/105/08 thru 7/14/10

PATIENT CLINICAL HISTORY SUMMARY

The patient has MRI proven lumbar radiculopathy that has progressed despite excellent conservative care. Designated Doctor exam states that the patient is not at MMI. He recommends surgical work-up. A new MRI has been denied by the insurance company as medically unnecessary.

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

The diagnosis of lumbar radiculopathy has been made. Although the patient's symptoms have worsened, there is no evidence of any new neurological levels. The MRI is not necessary for surgery in this patient.

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)**