

SENT VIA EMAIL OR FAX ON
Oct/08/2010

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Lumbar Spine

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics. Medical Director of 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

641 pages from the Carrier 6/4/05 thru 9/23/10

Denial Letters 8/10/10 and 7/20/10

X-Rays 6/4/05, 9/2/05, 5/30/06, 4/3/07, 6/7/07, 6/8/07, 7/26/07, 10/25/07, 11/5/07, 10/1/08, 3/2/09

MRIs 7/18/05, 4/3/07, 7/26/07, 10/5/09

Tests 4/18/06 thru 10/1/08

EMGs 3/14/06 and 3/27/07

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of xx/xx/xx. The claimant reported an injury xx/xx/xx. She was pushing pallets and felt low back pain. In June of 2007 she underwent disc surgery at L45. She continued to have low back pain. There is left quadriceps weakness and left anterior tibialis weakness. There is a positive straight leg raise. EMG shows L45/L45 nerve irritation. The last MRI was 10/2009 that shows L3/4 stenosis and impingement of the L3

nerve root. Surgical fusion has been denied.

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

Base on the ODG low back pain guidelines, MRI are the test of choice for patients with prior back surgery. MRIs are indicated if there has been progression of neurologic deficit. This patient does have neurologic findings with muscle weakness and +SLR. It is not clear if there is progression. However, MRI is indicated as there was previous nerve compression and EMG is positive.

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)