

SENT VIA EMAIL OR FAX ON
Aug/26/2010

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Aug/24/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI of the lumbar spine without contrast

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD Board Certified in Internal Medicine

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 6/22/10, 7/7/10, 7/8/10
6/22/10 and 7/8/10
MRI 9/30/09
DDE 3/22/10
Medicine 6/16/10 thru 7/6/10

PATIENT CLINICAL HISTORY SUMMARY

Mr. sustained a fall injury . The records indicate he fell on his right knee. Knee MRI showed a small effusion. Leg MRI was normal. EMG/NCV demonstrated a right peroneal nerve injury. The first mention of back pain is in a June 16, 2010 note with Dr., indicating was having back pain and had been having this since the date of injury. Lumbar MRI was ordered to evaluate for a structural lesion as the cause of the ongoing symptoms.

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

Mr. injured his right knee during a fall in xx/xx/xx. MRI of the knee was unremarkable. The first mention of back pain in the records provided is in xx/xx, 14 months after the date of injury. Physical examinations have not found radiculopathic findings.

Lumbar MRI is recommended for evaluation of low back pain under the following circumstances: trauma with neurological deficit, suspicion for cancer or infection, progressive neurological deficit, myelopathy, cauda equina syndrome, or failure of at least one month of conservative care. Mr. does not fulfill these criteria. Therefore, the use of lumbar MRI at this time is not medically necessary.

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)