

I-Resolutions Inc.

An Independent Review Organization
8836 Colberg Dr.
Austin, TX 78749
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Lumbar without contrast

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management
Board Certified in Electrodiagnostic Medicine
Residency Training Physical Medicine and Rehabilitation and Orthopedic 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

Adverse Determination Letter, 3/22/11

M.D. 3/16/11 to 3/28/11

Medical Clinic 3/16/11

Official Disability Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a XX year-old man who reportedly injured his back on XX/XX/XXXX. There are no medical records regarding what treatments were instituted. Dr. wrote on 3/16/11 of increased back pain and numbness. The examination described left paravertebral tenderness and positive left straight leg raising, Gaenslen and Patrick tests. There is reduced lumbar motion and spasm. The neurological exam described marked decreased sensation to light touch at the left lateral thigh and medial calf. The left knee jerk is also reduced. Dr. wrote that this was the date of his initial assessment and yet his treatment was unchanged from the last visit. The 3/28/11 note is about the same on the examination without changing. The 3/16/11 x-ray showed an L2/3 and L3/4 retrolisthesis.

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

According to the ODG, repeat MRI is justified if there has been a significant change in symptoms or physical findings. This patient's provider, Dr., apparently has no medical records to go by. In the note of 3/16/11 Dr. states "Patient was approved for a one time visit.

Contacted his previous treating physicians. There are no available medical records for review.” There is no description of any surgical procedure or scar on exam. The providing doctor does not know if there is any true change in the status of this person. Because of the lack of records available for review, these could be new and progressive symptoms. His pain and radicular symptoms are worsening. There is a medical necessity at this time for MRI Lumbar without 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)