

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of Lumbar and MRI of Cervical

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

Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinic notes dated 08/29/12-10/08/12
Peer review dated 11/01/09
Prior reviews dated 09/20/12 and 09/27/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. The patient was initially treated for neck and low back pain. Prior procedures included cervical rhizotomy and prior electrodiagnostic studies were negative for evidence of radiculopathy. Clinic notes indicate the claimant did undergo prior MRI studies of cervical spine and lumbar spine; however, these were not provided for review. The patient continued to receive chiropractic therapy through 09/12. The patient did report improvement in pain with chiropractic therapy. Clinical evaluation on 10/01/12 reported loss of lumbar range of motion. Follow-up on 10/08/12 revealed loss of lumbar range of motion as well as decreased sensation in right C7 dermatome.

The request for MRI of the cervical spine and lumbar spine was denied by utilization review on 09/20/12 as there were no neurological findings to support new MRI studies of the neck or low back.

The request was again denied by utilization review on 09/27/12 as there was no indication of

significant change in symptoms or progressive neurologic deficit.

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

The request for MRI of cervical spine and lumbar spine is not recommended as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. Based on the clinical documentation provided for review, there is no objective evidence of severe or progressive neurological deficit that would reasonably require repeat MRI studies of neck or low back. The patient continues to receive chiropractic therapy for neck and low back pain through 09/12; however, clinical documentation does not establish there has been any significant worsening of neurological findings that would require repeat MRI studies at this point in time. Additionally, no interval plain film radiographs have been performed since 2007 ruling out any other pathology that can be contributing to the patient's symptoms. As the clinical documentation provided for review does not meet guideline recommendations for the request, medical necessity is not established.

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)