

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jun/26/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI of the Spine without contrast

**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  
MRIs of the lumbar spine dated 07/22/10 & 11/05/11  
Clinical notes dated 05/29/12 – 05/16/13  
Court decisions and orders dated 10/19/12 & 10/22/12  
Previous utilization reviews dated 05/23/13 & 06/04/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury regarding his low back. The MRI dated 11/05/11 revealed moderate central spinal stenosis at the L4-5 level with some compromise of the lateral recesses. A posterolateral disc herniation was noted on the right at L3-4 with moderate compromise of the right neuroforamen. The clinical note dated 05/29/12 details the patient continuing with low back pain. The patient was able to demonstrate 5/5 strength throughout the lower extremities. The clinical note dated 06/25/12 details the patient continuing with low back pain. Reflexes were noted to be 1+ throughout the bilateral lower extremities. The clinical note dated 07/17/12 details the patient stating the initial injury occurred when he attempted to lift a security gate when it became jammed and he felt a pop in his low back with an immediate onset of pain. The patient was noted to have undergone physical rehabilitation with no significant benefit. The patient rated his pain as 5-6/10 at that time. The patient did report symptoms of depression and anxiety disorders. The clinical note dated 05/16/13 details the patient continuing with low back and right lower extremity pain for greater than 3 years. No issues with the patient's bladder and bowel control were noted.

The previous utilization review dated 05/23/13 resulted in a denial for a MRI of the lumbar spine secondary to a lack of significant changes involving the patient's symptoms or a development of any significant pathology.

The previous utilization review dated 06/04/13 for a MRI of the lumbar spine resulted in a denial secondary to no mention of the patient's significant changes involving the pathology or symptomology.

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

The documentation submitted for review elaborates the patient complaining of low back pain. The patient is also noted to have previously undergone a MRI of the lumbar spine. The Official Disability Guidelines recommend a repeat MRI of the lumbar spine provided the patient meets specific criteria to include significant changes involving either pathology or symptomology. No information was submitted regarding the patient's development of any significant changes involving the pathology or symptomology. Given that no information was submitted regarding the patient's significant changes involving either the pathology or symptomology, this request does not meet guideline recommendations. As such, it is the opinion of the reviewer that the request for a MRI of the lumbar spine without contrast is not recommended as 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)