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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/03/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Lumbar without contrast

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

Neurosurgery

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:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 04/09/03 – 03/26/13
Operative report dated 07/23/03
Operative report dated 07/31/03
MRI of the lumbar spine dated 06/18/04
Psychological evaluation dated 08/30/05
Operative report dated 04/08/10
Previous utilization reviews dated 04/09/13 & 04/18/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his low back. The MRI of the lumbar spine dated 06/18/04 revealed postoperative changes from the previous decompressive laminectomy and discectomy at L4-5. The clinical note dated 04/06/06 details the patient complaining of low back pain with radiating pain to the L5 distribution. The note does detail the patient utilizing chiropractic manipulation for ongoing pain relief. The operative report dated 04/08/10 details the patient undergoing a laminotomy and discectomy redo on the left at L4-5. The patient complaining of an increase in pain in the lower extremities. The clinical note dated 04/29/10 details the patient's pain being well controlled. No deficits were noted with activities of daily living. The clinical note dated 03/06/13 details the patient continuing with low back pain. The patient stated he has difficulty ambulating or climbing stairs. X-rays completed on 03/26/13 revealed settling at the L4-5 level with minor anterior osteoarthritic lipping settling on L5-S1. Excellent alignment was noted.

The previous utilization review dated 04/09/13 for a repeat MRI of the lumbar spine resulted in a denial secondary to the patient demonstrating no neurologic evidence of radiculopathy or significant changes involving the patient's neurologic deficits or functional deficits.

The utilization review dated 04/18/13 for a repeat MRI of the lumbar region resulted in a denial secondary to demonstrating no neurologic deficits associated with the lumbar region.

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 ongoing low back pain despite a number of surgical interventions. The Official Disability Guidelines recommend a repeat MRI provided the patient meets specific criteria to include significant changes in the patient's pathology or symptomology. No information was submitted regarding the patient's significant changes involving either the pathology or symptomology. No neurologic deficits were noted by exam. Given that no information was submitted regarding the patient's significant changes involving the pathology or symptomology, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a repeat MRI of the lumbar spine without contract 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)