

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Mar/25/2014

**IRO CASE #:**

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

Repeat MRI Lumbar w/o contrast

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

Board Certified Anesthesiologist

**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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his low back. An MRI of the lumbar spine dated 04/11/05 revealed degenerative changes at multiple levels. Mild diffuse disc bulge was identified at L4-5. Clinical note dated 02/26/07 indicated the patient had a recent fall resulting in two broken ribs. The patient also had complaints of mid-thoracic spine pain described as moderately dull and stabbing sensation. The patient had a current smoking habit at this time. Clinical note dated 12/13/11 indicated the patient complaining of pain radiating from the low back into the left buttock. Stiffness and spasms were identified. The patient rated the pain as 4/10. A clinical note dated 03/13/12 indicated the patient continuing with stiffness and spasms. The patient was utilizing Lortab at this time for pain relief. A clinical note dated 03/25/13 reported the patient rated his pain at 2/10 with use of pain medications. Clinical note dated 06/25/13 indicated the patient reporting 7/10 pain. Clinical note dated 10/29/13 indicated the patient continuing with 5/10 pain. The patient demonstrated normal gait and station. Clinical note dated 01/30/14 indicated the patient complaining of aching, burning, cramping sensation. Utilization review dated 02/14/14 resulted in denial for repeat MRI as no objective exam findings were submitted suggestive of progressive neurological injury or a new spine pathology identified. The utilization review dated 02/16/14 resulted in denial for MRI of the lumbar spine as no information was submitted indicating any red flags or progressive neurological deficits.

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

The documentation indicates the patient having a long history of low back pain. An MRI of the lumbar spine would be indicated upon completion of all conservative treatments. No information was submitted regarding previous involvement with conservative treatment addressing low back complaints. Additionally, there does not appear to be any progression of the low back symptoms including any radiculopathy. Given these findings, this request is not indicated. As such, it is the opinion of the reviewer that the request for MRI of the lumbar spine 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

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)