

# Pure Resolutions LLC

An Independent Review Organization

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## Notice of Independent Review Decision

Case Number:

Date of Notice: 01/21/2016

### Review Outcome:

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

### Description of the service or services in dispute:

MRI of the lumbar spine without contrast

**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)

### Patient Clinical History (Summary)

This patient is a male who reported an injury on XX/XX/XX after performing a Functional Capacity Evaluation. Of note, this patient has undergone multiple lumbar spine surgeries including an L5-S1 revision laminectomy and decompression discectomy with fusion in XXXX. Per the most recent MRI provided for review, the patient had findings in XXXX of postoperative changes in the L5-S1 level with no disc herniations or spinal stenosis seen. On XX/XX/XX, the patient underwent a removal of hardware at the L5-S1 with an additional revision laminectomy, facetectomy, foraminectomy, and decompression of the L5 and sacral nerve roots, and revision posterior spinal fusion with BMAC tissue allograft and autograft. The most recent clinical evaluation provided of the patient was dated XX/XX/XX. During this evaluation, it was stated that the patient reported worsening back pain that radiated over the tailbone. The pain was worse with activity. Upon evaluation, the patient had range of motion at flexion of 50 degrees, hyperextension of 15 degrees, and bilateral lateral bending at 15 degrees. There was pain associated with motion. During this time, he was diagnosed with lumbosacral spinal stenosis and a herniated lumbar disc. It was recommended that the patient undergo an additional MRI. This request is regarding the medical necessity of the requested lumbar spine MRI.

**Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.**

The requested lumbar spine MRI is not supported. Per the Official Disability Guidelines, MRIs are the test of choice for patients with prior back surgery. However, repeat MRI is not routinely recommended and should be reserved for significant change in symptoms and/or findings suggestive of significant pathology after the failure of recommended conservative therapies. The documentation submitted for review does show that this patient has had multiple lumbar spine surgeries with the most recent being in XXXX. However, while the patient complains of pain in the lumbar spine, no recent clinical documentation was submitted regarding his current condition to support that he requires an MRI. Additionally, information was not provided to support that he has undergone any conservative treatment in regard to his low back pain. Likewise, the

documentation provided failed to show that the patient has had any significant changes in her symptoms that would support the request for an additional MRI. Without this information, the request would not be supported by the evidence based guidelines. Given the above, the prior denial of the lumbar MRI should be upheld.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)