Becket Systems

An Independent Review Organization
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Description of the service or services in dispute:

MRI without contrast for the XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX. The biomechanics of the injury were not available in the records. XXXX was diagnosed with pain in XX XX (XX.XX).

On XXXX, XXXX was seen by XXXX for XX XX pain. XXXX had undergone XX XX surgery. XXXX was doing well with a much better range of motion and much better function. XXXX also complained of XX pain. The examination of the XX showed a much better range of motion, nearly full slight XX signs and mild weakness noted. The XX continued to show some XX-type signs with limited internal rotation with extension. XXXX recommended an MRI of the XX to rule out a XX XX.

The treatment to date included medications (XXXX), and physical therapy.

Per a utilization review decision letter dated XXXX and a peer review dated XXXX, the requested service of an MRI of the XX was denied. "Rationale: The available documentation noted possible XX signs. This implies that XX pathology may be active. As per guidelines, XX injury is best imaged with XX of optimized XX protocol with XX magnet. This is not specified as such on the order, thus the request is not medically necessary at this time. Therefore, the request for MRI without contrast for XX XX was not medically necessary". The poorly scanned medical record was largely illegible.

Per a utilization review decision letter dated XXXX and peer review dated XXXX, the prior denial was upheld. Rationale: "XX MRI was recommended for XX, XX or soft tissue XX, XX, XX XX, and stress fracture, acute and XX soft tissue XX, and XX. Additionally, MR arthrography or MRI with a XX.0 magnet was recommended for the assessment of XX XX". In the case, the provided documentation revealed a complaint of XX XX / XX pain. The physical examination revealed painful internal and external rotation with the clinician noting that XX signs could also be noted. There was no evidence of requested MRI would be performed with XX.0 T magnet. Furthermore, there was no indication of recommendation for a non-arthrogram MRI. Therefore, the appeal for an MRI of the XX XX without contrast was not medically necessary. The poorly scanned medical record was largely illegible.

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

The ODG recommends XX arthrography or MRI with a XX.0-Tesla magnet for the assessment of XX tears of the XX. The provided documentation reveals XX -type symptoms of the XX with a recommendation for an MRI to rule out a XX tear. There is no evidence that the MRI is to be performed with a XX.0-Tesla magnet and there is no rationale provided for why a non-arthrogram MRI is recommended for the assessment of a XX XX of the XX. Based on the provided documentation and ODG recommendation, recommendation is for upholding the previous denials. Given the documentation available, the requested service(s) is considered not 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 and Environmental Medicine

☐ AHRQ-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

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XX

☐ 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 Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.