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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI XX

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

Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XXXX who was injured on XXXX. XXXX.

On XXXX., evaluated the patient at **XXXX**). The patient reported pain in the XX XX, down to XXXX legs. XX. The XX XX pain radiated to XX XX thighs with XX/XX. On exam, there was tenderness in the XX region XX. Seated straight leg raising (SLR) test was XX. Deep tendon reflexes (DTR) were XX. The patient was able XX XX heel and toe walking. XXXX had a full range of motion (ROM) with pain on XX/XX. The diagnoses were XX strain/sprain, XX disc XX/XX. **XXXX** were prescribed. Light duty restrictions were recommended. The patient was advised heat/cold application and XX.

On **XXXX**, X-rays of the XX XX showed disc space XX. There were marginal XX throughout the XX.

On **XXXX**, the patient was reevaluated by XXXX. The patient reported tightness in the XX XX. XX XX/XX. On exam, there was tenderness in the XX XX of the XX region. The seated XX test was XX. DTRs were XX. Toe/foot XX was XX. The pain was noted with XX (XX to mid XX) and extension. The axial loading test was XX. Medications, XX, therapy and work

restrictions were continued.

On **XXXX**, the patient reported continued XX. XX XX/10. Physical Therapy (PT) was scheduled. The examination was notable for improved ROM. The plan was to complete the PT. Medications and light duty were continued.

On **XXXX**, XXXX noted the patient did a lot of walking and felt pain in XX the XX XX down to the XX. XX XX/10. The exam revealed tenderness in the XX XX region, XX XX, symmetric XX, improved ROM with pain. The plan was to continue medications, XX, therapy and restricted duty.

On **XXXX**, XXXX evaluated the patient in a follow-up visit. The patient had XX a XX on XX and XX over. XX XX/10. On exam, there was tenderness in the XX XX XX. XX test was XX. Extensor XX XX (XX) strength was XX/5. The XX and XX XX of the feet was good. The extension was limited. XX with fingers was up to the XX-XX. XXXX continued the medications and ordered a magnetic resonance imaging (MRI) of the XX XX.

On **XXXX**, **XXXX**., performed a utilization review and denied the request for MRI of the XX XX. Rationale: "*According to the Official Disability Guidelines, imaging studies are indicated on the basis of documentation noting XX on physical examination despite non-operative care. The clinical documentation submitted for review indicated this patient had XX XX pain. However, there was no documentation noting significant quantitative objective findings indicative of XX on physical examination. Further, there was no information noting the failure of non-operative care. Consequently, the request is not supported. As such, the requested MRI of the XX XX without contrast, as Outpatient is not medically necessary."*

On **XXXX**, XXXX was notified about the denial.

On **XXXX**, XXXX reevaluated the patient in a follow-up visit at OHS. The patient continued to experience some pain when on XX for a long time. XXXX had XX down to XX. XX XX/10. The examination remained unchanged. The diagnoses were XX sprain/strain and XX disc XX. XXXX was prescribed.

On **XXXX**., performed a reconsideration and upheld the denial of MRI of the XX XX. Rationale: *"The claimant is a* **XXXX** *with an original date of injury on* **XXXX**. *The XX body part is the XX XX. The request is for an MRI of the XX XX.* **XXXX**, *indicated that the claimant for the most part has been working with intermittent XX pain for many years. XXXX states that over the last couple of months, the XX pain has become more severe, more constant and it is radiating into XX XX XX. I discussed with XXXX the fact that XXXX physical examination findings, which are illegible, do not identify clinical evidence of XX. There is no identification of XX reflexes or XX sensation. There is no indication that straight leg raising is producing any type of XX XX, and I discussed with XXXX the fact that without clinical findings to substantiate XX, an MRI would not be indicated. XXXX indicated that based on what the claimant has told XXXX of significant increasing pain over the last couple of months, even though XXXX was sent for physical therapy for what was allowed, XXXX said was XX sessions, and XXXX was instructed in-home exercises, which do help XXXX somewhat. XXXX feels that XXXX needs to*

send XXXX for a consultation with an orthopedist and XXXX is going to do that. I did discuss with XXXX that if the orthopedic evaluation indicates the necessity for an MRI, XXXX can re-request it. XXXX was in agreement with that."

On **XXXX**, the patient reported pain in the XX XX XX when standing. XX XX/10. The examination remained unchanged. **XXXX**, XX and light duty were continued.

On **XXXX**, XXXX was notified about the denial.

On **XXXX**, XXXX reevaluated the patient in a follow-up visit. The patient complained of pain in the XX and XX the XX. XX XX/10. On exam, the XX test was XX on the right side at XX degrees with XX pain. EHL strength was XX/5. The ROM was limited in extension. XX with XX was up to mid-shin. **XXXX** were prescribed. The patient was advised to continue XX and restricted duty.

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

The medical records have been reviewed and XXXX has been treated with therapy and medications for greater than a XX. In addition, the pain has been progressive and XXXX has a XX straight leg raise indicating a XX. Per ODG uncomplicated XX XX pain, with XX, after at least XX month of conservative therapy, sooner if severe or progressive neurologic deficit. Therefore, it is my opinion the decision be overturned.

☒ Medically Necessary

☐ Not Medically Necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**