Magnolia Reviews of Texas, LLC

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01/16/2018

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Cervical Spine

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

Board Certified in Family Medicine by the American Board of Family Medicine.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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

The requested MRI Cervical spine is not medically necessary and the prior determination is upheld.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a XX-year-old XXXX with history of an occupational claim from **XXXXX.** The mechanism of injury was detailed as occurring when the patient **XXXXX**. The clinical note from **XXXXX** noted that the patient reported neck pain that was achy, tender and pressure-like and was moderate. Timing was constant. Modifying factors included prescription medications, nonsteroidal anti-inflammatory drugs and over-the-counter medications. The patient had discomfort, trouble sleeping, radiating pain, joint pain and joint stiffness. On examination, the neck was supple and the trachea is midline. There was mild tenderness to the right sternocleidomastoid muscle and upper/middle/lower trapezius muscle and rhomboid muscle. There was full active range of motion with mild pain/spasm with rotation and lateral bending. The patient was to undergo an MRI.

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

The Official Disability Guidelines note that MRI's are recommended for patients with chronic neck pain after 3 months of conservative teat, if radiographs are normal and there are neurologic signs or

symptoms present. The documentation indicates that the patient had continued complaints of neck pain. There was tenderness to the right sternocleidomastoid muscle and the upper/middle/lower trapezius muscle and rhomboid. The patient has had improvement with previous use of medications. However, there was no indication that the patient had completed all conservative treatment including physical therapy. Also, there was no clear evidence of neurological signs or symptoms present on examination. As such, the request for MRI cervical spine is not medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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

☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES, Neck and Upper Back, Magnetic resonance imaging (MRI)**