# Icon Medical Solutions, Inc.

**P.O. BOX 169**
**Troup, TX 75789**
**P 903.749.4272**
**F 888.663.6614**

**DATE:** 10/4/18

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** MRI XX XX WO Contrast

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
The reviewer is certified by The American Board of Anesthesiology with over 11 years of experience.

**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]:**
Claimant is a XXXX that acquired a work-related injury on XXXX. Claimant working XXXX.

XXXX: XX XX X-Ray. Impression- Mild degenerative change without acute bony abnormality.

XXXX: Office Visit with XXXX. S/p XX XX, Rhomboid and Thoracic XX. 60% relief. Neck feels great but continues to c/o low XX pain. None of the injections done for XXXX XX have helped (XX). Pain is sharp, stabby, dull, achy and burning. Sharp, aching, radiating. Best 3/10. Worst 10/10. Current 3/10. Occasional XX buttock and tingling in XXXX rt heel. Better with medication and injections. Worse with standing and walking. PT is helping. Meds: XXXX. Minimal paraXX muscle spasm appreciated in XX, XX; mainly on XX side on physical examination.

XXXX: Initial Visit with XXXX. Able to stand up from sitting with mild difficulty due to pain. XXXX appears uncomfortable with certain movements and grabs the area of the XX buttock where most of XXXX pain is. 5/5 strength in gastrocnemius soleus and tibialis anterior, however, 4/5 in iliopsoas and quad XX due to pain. Pt brought previous MRI dated XXXX, showing moderate-severe central and several XX XX-5 stenosis, moderate-severe XX recess stenosis at XX-XX. Likely with pressure on the transversing XX and XX nerve roots. There is

transitional anatomy. XX-2 XX is open. There may be option of surgical decompression. If we decide to go that route, I would need to obtain a new MRI.

XXXX: DDE, XXXX. XX- After considering all differentiators, the examinee's subjective symptoms and the medical records, it is determined the examinee's injury is best rated under Table 72 DRE Category II, for 5% whole person impairment of the XX XX. 5% total whole person impairment.

XXXX: F/U Visit with XXXX. Low XX pain that radiates down XX. Aching, throbbing and gnawing. Constant, with activity, daily. Pain is 8/10. Made worse by walking, lifting and sitting. Pain wakes pt while sleeping. Due to vertigo, pt was unable to complete Physical Therapy. XXXX. Physical Exam- ParaXX palpitation has tenderness and spasms of the XX paraXX. Knee reflexes are 2+ symmetrically. Ankle reflexes are 2+ symmetrically. Assessment. 1. LBP. 2. XX Radiculopathy. 3. XX Stenosis, XX. Pt is very anxious about surgery, as XXXX continues to have pain worsening in XXXX XX, down XXXX legs. XXXX is having significant neurogenic claudication affecting XXXX ability to stand for any length of time or walk any distances.

XXXX: F/U with XXXX. Pt states XXXX pain is 8/10 and is getting worse. States XXXX overall symptoms have increased. ROM decreased. Radiating pain has increased RLE through buttock along XX of thigh to foot. Numbness and tingling increased into XX leg to calf. LE weakness remained the same, XX leg. Numbness over XX buttock into posterior thigh to calf and sometimes to XX foot- intermittent, comes and goes with pain. Add XXXX.

XXXX: F/U with XXXX. Surgery scheduled for XXXX. XX pain persists, along with numbness in XXXX XX leg and toes. Pain 7/10. Pt states overall, symptoms have decreased, pain is a little better. 8/10. ROM stayed same. Radiating pain has decreased to RLE to buttock. Numbness and tingling remained the same, rt leg is numb. Tingling in the toes of XXXX XX foot. LE weakness remained the same.

XXXX: F/U with XXXX. Pt states pain is getting worse because of the eval XXXX had in XXXX this past weekend. Continued numbness and tingling in XX leg and toes. Pain is 9/10.

XXXX: Post-DD RME by XXXX. I agree with the dx of XX strain/sprain. XX strain/sprain and concussion with LOC. The best supported date of MMI is XXXX, which was the assessment by the DD and concur with the 5% WP Impairment. I agree that the pt best satisfies cervicothoracic category I, 0%; XX category II, 5%, and for the head concussion per chapter 4, 0%.

XXXX: F/U with XXXX. Pt states XXXX wants to start XXXX on injections in neck and XX. XX pain 7-8/10. Pt states that overall symptoms have remained the same. ROM remained the same. Numbness and tingling remained the same, continued numbness and tingling, which extends down XXXX rt leg to the toes of XXXX XX foot. RLE weakness remained the same . Numbness over rt buttock when XXXX has radiation. Spasms in XXXX XX calf and rt XX thigh. XX XX- Inspection, XX deviation XX. ROM decreased in all planes. Flexion remained the same. Extension the same. Rotation the same, XX. LE- deep tendon, normal. Sensation normal. Muscle strength decreased RLE. Sitting SLR XX, negative.

XXXX: UR by XXXX. Rationale- There is no intervening event or progressing neurological change since the last MRI of XXXX. Repeat MRI is not supported.

XXXX: UR by XXXX. Rationale- Review of the medical notes did not find significant change in clinical presentation that would warrant reimaging. XXussion with provider did not provide additional information that would also warrant a change in clinical status or symptoms congruent with evidence base guidelines that would make repeat imaging necessary.

Letter of Medical Necessity from XXXX. Pt's diagnosis is XX radiculopathy. XXXX was first evaluated on XXXX, for an injury XXXX sustained on XXXX. Since initial injury, XXXX has suffered from chronic sharp neck and low XX pain. XXXX describes the pain as shooting electrical shocks going down XXXX legs into XXXX toes. XXXX has chronic numbness and tingling and decreased sensation. Pt also suffers from episodic weakness, leading to XXXX legs buckling and difficulty walking. Pt's physical exam is positive for straight leg raised, and seated slump test on the rt XX extremity. XXXX has severe tenderness to palpation over both the XX and XX XX, with decreased sensation in the XX, XX and XX dermatomal patterns. XXXX has diminished patellar reflexes in both LE. MRI XXXX revealed the pt had XX stenosis in levels XX-XX and had 1mm ventral bulging XXs in XX-XX as well. XX-XX XX canal narrowing to 3mm and XX-XX conveyed a boney XX canal narrowing to 7mm. Since our initial evaluation in XXXX, pt has failed conservative management with medications and is unable to successfully participate in physical therapy due to XXXX pain. XXXX persistent pain and problems have progressed to the point where XXXX is unable complete activities of daily living. In order for us to fully treat the pt with any interventions, we need to re-evaluate the XX with MRI to evaluate for nerve root compression.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The previous adverse determinations are overturned. Based on the changes in the patient's examination and continued pain and failure of conservative therapy, repeat MRI is justified. Therefore, the request for MRI XX XX WO is considered medically necessary.

PER ODG XX

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

☐ **ACOEM- AMERICAN 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 XX 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**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**