Specialty Independent Review Organization

Date notice sent to all parties: 10/2/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an MRI of the XX XX without contrast as Outpatient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

REVIEW OUTCOME:
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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an MRI of the XX XX without contrast as Outpatient.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, in a XXXX. The claimant was diagnosed with a strain of the XX, strain of the XX shoulder, strain of the XX XX, and strain of the XX wrist and hand. An evaluation on XXXX, noted the claimant was having continued pain in the XX shoulder and XX wrist, and the XX XX pain was worse with symptoms of radiculopathy in the XX XX extremity. The physical examination of the XX XX revealed tenderness to palpation with no muscle spasms. There was no significant guarding. Flexion alignment was straight without evidence of significant scoliosis. XX bending to the right and XX was within normal limits. There was no tenderness with extension. Decreased deep tendon reflex to the right knee was noted. There was full strength throughout the XX extremities. Sensation was intact to light touch in all distributions. There was no evidence of atrophy in the XX extremities. The gait was within normal limits. There was negative XX XX and negative XX. Range of motion was noted to be normal with flexion, extension, and XX bending.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
According to the guidelines, an MRI of the XX XX is recommended when there is evidence of a neurologic deficit after at least one month of conservative treatment to include therapy. There is no objective documentation supporting the claimant has completed at least one month of physical therapy. There is no neurologic deficit on clinical examination. A mild loss of deep tendon reflexes was noted to the right knee; however, there is no documentation of loss of sensation, loss of range of motion, significant tenderness to palpation, or a positive straight leg raise. Therefore, the request for an MRI of the XX XX without contrast as an outpatient is not medically necessary.

Official Disability Guidelines ODG Treatment Integrated Treatment/Disability Duration XX XX (Acute and Chronic) (updated XX) ODG guidelines MRI (magnetic resonance imaging)

Recommended for indications below. MRI is the test of choice for patients with prior XX surgery, but for uncomplicated XX XX pain with radiculopathy, this test is not recommended until after at least one month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (Anderson, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007)
Indications for imaging -- Magnetic resonance imaging:

- XX XX trauma: trauma, neurological deficit

- XX XX trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)

- Uncomplicated XX XX pain, suspicion of cancer, infection, other “red flags”

- Uncomplicated XX XX pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit.

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 XX 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)**