IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 1/17/2019

IRO CASE # XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"Repeat MRI XX XX" for the patient.

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

M.D. Board Certified in Physical Medicine and Rehabilitation.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a review regarding the medical necessity of a repeat MRI of the XX XX. The reported date of injury was XX when the patient reportedly was injured while XX. The patient subsequently was diagnosed with XX sided XX as well as muscle pain. MRI imaging of XX demonstrated mild to moderate XX changes with increasing XX XX XX. The patient reported ongoing pain. The most recent medical records date back to XX. The patient reported difficulty standing or walking for a prolonged time. XX was not being treated with medications at that time. On exam, the patient was noted to have tenderness to palpation of the XX XX joint and XX XX and pain with range of motion of the XX. MRI imaging of the XX XX and a XX was recommended.

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

Per ODG references, the requested "Repeat MRI XX XX" is not medically necessary. The Official Disability Guidelines discuss indications for MRI imaging of the XX XX. Repeat MRI imaging is not recommended unless there is a significant change in symptoms and/or findings suggestive of significant pathology such as a neural compression, fracture, tumor or recurrent disc herniation. There is very limited clinical information at this time regarding the rationale for a repeat MRI. There is no information to suggest a fundamental change in the patient's clinical status meeting this criterion.

14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Without further clarification it is not possible to support a request for a repeat MRI. Therefore, in this situation the request is not medically necessary and should be noncertified.

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 KNOWLEDGE BASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK 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