Specialty Independent Review Organization

Date notice sent to all parties: 12/31/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of an MRI of the XX XX w/o contrast.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of an MRI of the XX XX w/o contrast.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. Past medical history was positive for XX and remote history of XX fracture at XX

The XXXX initial occupational medicine report cited complaints of XX XX pain with XX symptoms into both XX XX. XX XX x-rays dated XXXX were reviewed and showed no significant abnormalities. XXXX was unable to work due to stiffness and high pain level. Past medical history was positive for XX. Current medications included XXXX. XX XX exam documented limited range of motion in all planes secondary to pain, XX tenderness to palpation, normal XX muscle tone, and negative straight leg raise. XX XX neurologic exam documented

XX/5 strength, intact sensation, and XX and symmetrical deep tendon reflexes. The diagnosis included XX sprain and XX contusion. The treatment plan recommended physical therapy.

A review of records documented physical therapy was initiated on XXXX for a course of XX visits, XX.

The XXXX orthopedic report cited complaints of severe XX XX pain with XX symptoms secondary XXXX. XXXX was not working due to pain. XXXX could not take XX due to XX pain. Physical therapy was helping a little. XX XX exam documented tenderness of the XX and transverse processes and XX region at XX, and pain with active range of motion. Seated straight leg raise was positive XX, and the XX reflexes were diminished XX. The diagnosis included XX sprain. The treatment plan recommended MRI of the XX XX without contrast to rule-out XX nucleus pulposus versus worsening of prior compression fracture.

The XXXX peer review determination non-certified the request for XX XX MRI without contrast. The rationale stated that there were no objective clinical exam findings to support significant neurologic deficit of the XX XX and no documentation to support at least one month of conservative therapy to support the request.

The XXXX orthopedic report cited complaints of persistent XX XX pain with associated weakness. XX XX exam documented tenderness to palpation of the XX and XX processes at XX, XX XX joint tenderness, and restricted and painful range of motion. XX XX neurologic exam documented XX/5 strength and diminished XX XX reflexes. Seat straight leg raise was positive XX. The treatment plan recommended XX XX MRI without contrast due to severe pain, XX pain, and neurologic deficits. It was noted that the patient had XX weakness, positive straight leg raises and diminished range of motion due to pain. A XXXX injection was performed.

The XXXX peer review determination non-certified the reconsideration request for XX XX MRI without contrast. The rationale stated that there was no objective documentation of neurologic deficit. The physical exam findings did not document XX loss of strength, dermatomal loss of sensation, or absent reflexes to support the medical necessity for MRI in accordance with the guideline treatment recommendations.

The XXXX orthopedic report cited complaints of severe XX XX pain with weakness. XX XX exam documented tenderness to palpation of the XX XX XX and XX processes and XX XX joints. XX range of motion was limited and painful. XX XX neurologic exam documented XX/5 XX quadriceps weakness and diminished XX reflexes. Seated straight leg raise was XX XX. The diagnosis included XX ligamentous sprain. The treatment plan recommended MRI of the XX XX and additional physical therapy for XX visits.

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

The Official Disability Guidelines recommend MRI of the XX XX for specific indications including XX XX trauma with neurologic deficit and for uncomplicated XX XX pain, with XX, after at least XX 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)

This patient presents with persistent XX XX pain with associated weakness. Pain has limited function and precludes return to work. Clinical exam findings evidence motor weakness and reflex changes in an XX distribution. Detailed evidence of reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Given the history of trauma, documented neurologic deficits relative to motor deficit and reflex changes, and failure of at least XX month of conservative treatment, guideline criteria have been met. Therefore, this request for MRI of the XX XX without contrast is medically necessary.

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 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 (PROVIDE A DESCRIPTION)**