CASEREVIEW

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X: Operative Report by X, MD
X: Office Visit by X , PA for X MD
X : Office Visit by X , PA-C for X, MD
X: UR performed by X, MD
X: UR performed by X, MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a X who was injured during a X. According to an appeal letter by X, dated X, Dr. X ordered a X MRI to look at the X. It was felt that the claimant met other criteria listed in the ODG guidelines for X MRI, such as: X pain, new or progressive symptoms or clinical findings with history of X surgery and X to evaluate X. X treatment plan is dependent on the MRI findings.

On X, Operative Report by X, MD. PostOperative Diagnosis: 1. Multiple lumbar X including X, X. 2. Multiple X of the X. Procedure Performed: 1. Open X patient's X. 2. Posterior stabilization from X 3. X 4. Use of X. 5.X .

On X, the claimant presented to X, PA for X, MD for evaluation of X. X had X. It was X. On exam X was X in the X extremities X was intact in the X. Reflexes were X. AP, lateral x-ray of the X was performed and showed excellent placement of X. Plan: Order a CAT scan of the X further if there are any X, which may be causing the X.

On X, the claimant presented to X, PA-C for X, MD for X pain. The pain was X since X last clinic visit in X. The XX pain was most severe on the X side, X

tingling, and occasional X pain. X rated X pain as X and reported taking X on a XX basis. X pain was worse with certain activities or after staying in X for X of time. On examination X had XX along X. Sensation was normal and symmetric throughout. Strength was X in X. DTRs were normal throughout. Normal gait and posture. Plan: A long discussion took place about all possible treatment options available at this time; however, it was explain that they would need to obtain a MRI or CT of the X for further evaluation of the origin of the symptoms prior to making any final decision about the treatment plan. Therefore, a MRI of the X was ordered.

On X, X, MD performed a UR. Rationale for Denial: The Official Disability Guidelines, X chapter, only supports taking an MRI if radiographs are inconclusive and to investigate the X. No previous radiographic results are provided, and this patient has a normal X examination. Considering this physical examination, this request for an MRI of the X is not supported.

On X, X, MD performed a UR. Rationale for Denial: In this case, the X report indicates that the patient was last evaluated in X. The records do not establish that the patient has had any recent conservative care. Moreover, the patient is X intact upon physical examination. Examination findings are limited to X which is not an indication for magnetic resonance imaging. Medical necessity has not been established.

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

The request for X MRI is denied. This claimant underwent X in X for fractures of X. The X office note indicated that the patient had X pain, X, and X pain. X had no sensory or motor deficits on examination. X reflexes were intact. The treating provider recommended a MRI of the X XX.

The Official Disability Guidelines (ODG) supports MRI studies for patients with X pain with X. Computed tomography (CT) is the preferred imaging modality to evaluate X in post-op patients. In the absence of X on examination, MRI of the X is not 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)**