MEDRX

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DATE OF REVIEW: March 10, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI XX XX/MRI XX XX

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 Occupational Medicine.

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 medical necessity of: MRI XX XX/MRI XX XX

PATIENT CLINICAL HISTORY [SUMMARY]:
This is a XX-year-old XX who was XX XX on XX and afterwards XX a XX in XX XX with pain in the XX and XX XX. A XX XX x-ray suggested that XX had XX. A prior review had been performed on XX and it was noted that XX had sufficient treatment already. The records indicate that XX was seen at the XX on XX and XX was allowed to return to work on XX. It was noted that XX had a prior history of XX XX and chronic XX. XX was controlling XX XX with XX diet and had not taken any medicine for XX years. XX had been XX XX at least a XX a XX a XX but did not use XX XX. The XX did not find any XX deficit. XX XX-lead electrocardiogram was found to be normal. XX laboratory work was also found to be normal

including XX electrolytes as well as complete blood count and urinalysis. The provider requested XX sessions of outpatient therapy over XX weeks which was completed. XX had x-rays done at the XX and no fracture or dislocation was found. XX returned to the office of XX XX on XX. Handwritten notes reported that XX had been evaluated by the XX and the XX stated that XX had XX a XX of XX of XX and XX a XX in XX XX. XX did not XX, nothing XX on XX, and XX had no direct impact injury.

A designated doctor examination on XX noted that XX was a XX-year-old XX who had nonspecific pain on the XX more than the XX. XX had responded to muscle relaxers and occasional XX which XX got in the emergency room and had been treated by XX XX. After examination it was found that XX had reached maximal medical improvement. XX did not find any radiculopathy. XX was advised to work with restrictions of no squatting or lifting greater than XX pounds. XX was not given any other restrictions. At that time XX did not feel that XX was at maximum medical improvement.

The report of XX noted that XX was XX' XX" XX and weighed XX pounds. XX XX felt that XX had some pain in the muscles but XX does not describe any neuromuscular deficit or clinical findings of any radiculopathy. XX ordered MRIs of the XX and XX XX but does not show any evidence of radiculopathy or neuromuscular deficit to require such intervention. XX gave XX various chiropractic modalities on XX, XX, XX, and XX with a cost of $XX.

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

MRI of the XX XX/MRI of the XX XX are not medically necessary. This is a XX-year-old XX who had a XX of mid XX and XX pain. XX did not XX, nothing XX on XX, and XX had no direct impact injury. The medical records do not show any neuromuscular deficit and there is certainly no evidence of radiculopathy. As per the ODG guidelines there is no evidence of any radiculopathy or neuromuscular deficit. Therefore, the request for MRIs of the XX and XX XX is not medically appropriate or medically necessary according to the ODG guidelines of the XX XX and XX XX. I have reviewed all the data in the medical records including the emergency room records, XX examination performed by XX, and the various chiropractic treatments by XX as well as the history and physical examination of XX.

The XX XX chapter of the ODG guidelines acknowledges that one of the primary indications for requiring any MRI imaging is the presence of accompanied radicular symptoms after at least XX of conservative therapy. The required medical examination opined on XX that the claimant did not have active radicular symptoms or radicular signs. On XX the treating provider stated symptoms in the XX extremity including occasional numbness but XX does not provide symptoms in the distribution of any specific nerve root. I conclude that the medical records do not correlate with any radiculopathy or neuromuscular deficit. The MRI imaging is not medically indicated for the XX or XX XX as there are no radicular symptoms in the XX or XX extremities. It is not medically necessary or medically appropriate.

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**
  XX XX chapter
- ☐ **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)**