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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X

PATIENT CLINICAL HISTORY [SUMMARY]:
X who was injured on X. On X, X with X. X was diagnosed with X. X was seen by X, MD on X for a follow-up evaluation. X reported that the X. The pain was in the X, which was X and X. X denied any X, but X had X. X revealed X. X test and X tests were X. On X, was seen by Dr. X. X symptoms had X the prior visit. X examination revealed X. X test and X tests were X. X had X. X had X by being on a X. Dr. X treatment plan needed a X and should be confirmed by an MRI. If X had X, the X and X. X x-ray dated X was X. An MRI of the X demonstrated X. Other X or related X. X represented X change. There was X and X and X. Treatment to date included X. Per a utilization review dated X by X, MD, the request for MRI of the X was noncertified. Rationale, "Guidelines do not support repeat MRI for patients who were X. In addition, the clinical findings presented were insufficient to suggest X. There were no X or X that would X from the guidelines. Prior non-certification is upheld. Furthermore, during the peer discussion with Dr. X, the provider stated

that the patient had X. X symptoms are X. The patient has not had x-rays. The patient does not fully meet the criteria per ODG guidelines. No further X information was provided. There have been no recent plain films obtained on this situation. Patient appears to have X and is X and treating provider does not feel there is any need for X. It is unclear why further X testing should be performed. Therefore, all of the above requests are not supported." Per a utilization review dated X by X, MD, the request for MRI of the X without contrast was noncertified. Rationale, "Guidelines do not support repeat MRI for patients who were X. In addition, the clinical findings presented were insufficient to suggest X as there were not X. There were no X or X that would require X from the guidelines. Prior non-certification is upheld. Furthermore, during the peer discussion with Dr. X, the provider stated that the patient had X.X symptoms are X. The patient has not had x-rays. The patient does X per ODG guidelines. No further pertinent clinical information was provided. There have been no recent X. Patient appears to have X. It is unclear why further diagnostic testing should be performed. Therefore, all of the requests are not supported."

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

The ODG does not support repeat MRI for patients who are X. The provided documentation indicates the X. A X MRI from X showed a X. On X, the X. X notes indicate there is some X. There is no evidence of X since the most X. Given the X and the X, MRI is not supported.

Based on the available information, X for the X is not medically necessary. Recommendation is to uphold the prior denials.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL