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PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. X on some X. X reported X. The diagnosis was pain in the X. X was evaluated by X, MD X for a follow-up of X. Examination of the X showed X. X was noted. An MRI of the X dated X showed a X. There was X. X along the X was noted. There was also X along the X. The treatment to date included medications X. Per a utilization review decision letter dated X, the request for an MRI of the X was denied by X, DO. Rationale: "The ODG does not routinely recommend a repeat MRI for X conditions unless there is X. In consideration of the review documentation provided, it is suggested that the injured worker has X. They previously had an MRI on X that demonstrated a X. On X examination there is X. There is no documentation to suggest that there has been a significant change in symptoms that may be suggestive of significant X to warrant a repeat MRI. It is also not clear what the MRI is being ordered to rule out and how the results of this updated MRI may alter the treatment plan. In considering the ODG and available information, MRI of the X is not medically necessary." Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "The ODG supports repeat MRI of the X. The documentation provided indicates the injured worker complains of X. A X examination documented X. Treatment has included X. An MRI of X in X documented no evidence of X. The treating provider has recommended a repeat X MRI. Based on the documentation provided, the medical necessity for a repeat MRI cannot be established as there is X. The request is recommended for noncertification."

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

Based on the clinical information provided, the request for MRI X is not recommended as medically necessary and the previous denials are upheld. Per a utilization review decision letter dated X, the request for an MRI of the X was denied by X, DO. Rationale: "The ODG does not routinely recommend a repeat MRI for X. In consideration of the review documentation provided, it is suggested that the injured worker has X. They previously had an MRI on X. On X examination there is X. There is no documentation to suggest that there has been a significant change in symptoms that may be suggestive of significant X to warrant a repeat MRI. It is also not clear what the MRI is being ordered to rule out and how the results of this updated MRI may alter the treatment plan. In considering the ODG and available information, MRI of the X is not medically necessary." Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "The ODG supports repeat MRI of the X. The documentation provided indicates the injured worker complains of X. A X examination documented X. Treatment has included X. An MRI of X in X documented no evidence of X. The treating provider has recommended X MRI. Based on the documentation provided, the medical necessity for a repeat MRI cannot be established as there is no documentation of X. The request is recommended for noncertification." There is insufficient information to support a change in determination, and the previous non-certification is upheld. MRI of the X dated X revealed X. There is X. There is X. Peer review dated X indicates that the extent of injury is a X. There is no documentation of a significant change in clinical presentation since the prior MRI was performed to support updated imaging at this time. It is unclear how an updated MRI would change the course of the patient's treatment.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and therefore, the decision is upheld.

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