



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: 08/25/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI Lumbar spine with and without contrast

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

Texas State Licensed MD Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 8/05/2008
2. Texas Dept of Insurance notice to URA of assignment of IRO 8/5/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 8/4/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 7/21/2008
6. letter 8/04/2008
7. reconsideration/appeal letter 7/30/2008
8. utilization review determination letter 7/18/2008
9. M.D. office note 7/3/2008
10. Diagnostic CT Spine L W C 10/1/2007
11. ODG Guidelines were not provide by URA

PATIENT CLINICAL HISTORY:

DOI: xx//xx/xx, patient still complains has low back pain as well as upper back pain. They have been seen for thoracic and lumbar as well as cervical. The patient had a CT myelogram carried out on October 1, 2007. At that time, a laminectomy was demonstrated at L-3 and moderate



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stenosis noted at L4-5. It is noted that the patient has had a previous MR scan in September of 2006. That showed facet hypertrophy at L2-3, L3-4, and L4-5.

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

The last clinic note dated July 3, 2008 indicates that the patient does not have any leg symptoms. It does not indicate any new neurologic findings. The patient does not fulfill ODG Guidelines for an updated MRI scan. The previous adverse determination should be 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 KNOWLEDGBASE
- 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



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FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)