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

**DATE OF REVIEW:** **05/19/2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Magnetic Resonance (EG, Proton) Imaging, Spinal Canal and Contents, Lumbar; Without Contrast on 03/05/2008

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
Texas State Licensed MD Board Certified Orthopaedic Surgeon

**REVIEW OUTCOME** Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld
☒ (Ag
☐ ree) 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.

**PATIENT CLINICAL HISTORY:**
This individual was involved in an accident on XX/XX/XX. The patient has subsequently had treatment including chiropractic treatment, physical therapy, and facet blocks.
The patient underwent MR scanning on June 27, 2005. That MR scan showed significant changes at the L4-5 level. These were positive to the left with subarticular disk herniation. This caused deformity of the lateral recess.
The current physician assessed this patient on February 21, 2008. At that time, it was noted that the patient had bilateral leg pain worse on the left than on the right side. The leg pain was radicular in nature. He also demonstrated weakness in the dorsiflexors.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**
This patient has radicular symptoms with new findings in straight leg raising, nerve retention and weak dorsiflexors. In my opinion, this patient fulfilled criteria for updated MRI scanning. In my opinion, the MR scan is reasonable using ODG Guidelines as well as medical judgment, clinical

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experience, and expertise in accordance with accepted medical standards. In my opinion, the previous review outcome should be overturned.

**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)