



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



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

04/12/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 04/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI thoracic & post laminectomy

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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 03/23/2010
2. Notice of assignment to URA 03/23/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 03/19/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/12/2010
6. Pre-auth rqst 02/17/2010, 01/28/2010, email 02/22/2010, 02/02/2010, treatment plan 01/11/2010, 12/21/2009, 12/07/2009, medical review 09/10/2008
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient has transaxial pain. Records states the patient has chronic intractable pain as a result of an injury in xx/xx and since that time has had an anterior cervical decompression with fusion. He is willing to try another spinal cord stimulator but also has thoracolumbar disk disease as a result of workman's compensation injury. The patient has had an anterior cervical decompression, C4-C5, in 2004. A spinal cord stimulator trial in 2007. Patient is on



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



hydrocodone, Zanaflex, Tramadol, Motrin, Tylenol, and was on a fentanyl patch, which did not help. The request is for reconsideration for MRI thoracic & post laminectomy.

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

Refer to the Official Disability Guidelines' chapter on neck and upper back for MRI, states that the MRI indications are for chronic pain greater than 3 months with neurological signs present or it states neck pain with radiculopathy. The records do not support a reason why a thoracic or a lumbar spine MRI should be done. The documentation is insufficient, and does not support the medical necessity of the request; 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
- 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)