



Medwork Independent Review

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

12/10/2010

DATE OF REVIEW: 12/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI lumbar & EMG/NCV to bilateral lower

**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 & Spine 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 11/22/2010
2. Notice of assignment to URA 11/22/2010
3. Confirmation of Receipt of a Request for a Review by an IRO
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/13/2010
6. Letter to IRO 11/24/2010, letter 09/29/2010, denial letter 09/23/2010, letter 09/10/2010, 11/03/2009, pre-auth, medical note 07/22/2010, 05/11/2010, 02/08/2010, 12/28/2009, 10/05/2009, 10/19/2004, MRI 11/05/2003, medical note 11/25/2003, 10/01/2003, 03/02/2001, 01/15/2001, 08/22/2000, 08/10/2000, 03/14/2000, 01/24/2000, 01/18/2000, 01/12/2000, 12/28/1999, 10/28/1999, 10/08/1999, 09/08/1999, 09/01/1999, 08/26/1999, 07/27/1999, MRI 06/18/1999, medical note 06/11/1999, 06/04/1999, 05/13/1999, 03/18/1999, 03/15/1999, 02/04/1999, 12/17/1998, 09/10/1997, 06/10/1997, 04/15/1996, MRI 03/29/1996, 03/28/1996, medical note 12/26/1995, 11/29/1995, 02/02/1995, TDI forms 08/21/1995 & 01/26/1995, incarceration medical records: 04/12/2002, 05/09/2002, 05/10/2002, 05/16/2002, 06/22/2002, 05/21/2007, 06/02/2007, 06/17/2007, 06/20/2007, 06/25/2007, 06/28/2007, 06/30/2007, 03/21/2008, 03/24/2008, 04/14/2008, 05/08/2008, 08/07/2008, 05/15/2008, 05/17/2008, 05/20/2008, 05/30/2008, 06/03/2008, 06/06/2008, 06/05/2008, immunization record, note 06/23/2008, 08/15/2008, CT 07/30/2008, note 10/09/2008, 10/29/2008, 11/14/2008, 12/01/2008, 12/29/2008,
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:



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Claimant is a male that has a history of injury on xx/xx/xx. He subsequently had some low back pain with radiation into the right lower extremity. An EMG carried out in xxxx suggested a radiculopathy. Myelogram and post-myelogram CT were undertaken. This suggested a right-sided L4-L5 disk herniation. He was subsequently treated with physical therapy and multiple epidural steroid injections. In 1999, an MRI scan was carried out. This did not show any discrete disk herniation. The patient continued to have pain, which increased. In 2001 there was bilateral leg pain. MRI scan was carried out in 2003. No disk herniation was identified. There was no neural compression. The patient continued to have complaints of back pain with intermittent leg involvement. In 2008, a CT scan of the lumbar spine was carried out. This was interpreted as basically normal. There was no disk herniation or nerve root compression. Review request is for repeat of MRI lumbar & EMG/NCV to bilateral lower.

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

Based on Official Disability Guidelines, the previous adverse determination is upheld for the requested MRI & EMG/NCV to bilateral lower. The claimant has had two previous MRIs, a CT, myelogram and EMG/NCV. The patient has not demonstrated any discrete neurologic deficits that would merit a repeat MRI and EMG/NCV. The request is not in support of the OGD recommendations; therefore, the insurer's decision to deny 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 KNOWLEDGBASE
- AHCP- 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
- OGD- 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)