



## 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)*

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

---

**DATE OF REVIEW: 12/22/2009**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar myelogram with CT scan

**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 & 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 12/28/2009
2. Notice of assignment to URA 12/18/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 12/08/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/07/2009
6. letter 11/19/2009, 11/02/2009, 10/13/2008, 09/08/2008
7. Fax auth rqst 12/07/2009, psychotherapy 12/02/2009, 11/27/2009, letter 11/09/2009, mental hlth assessment 11/02/2009, note 10/28/2009, FAC eval 10/28/2009, radiology report 10/26/2009, letter 10/26/2009, note 09/30/2009, TDI form 09/22/2009, NCS/EMG 09/25/2008, note 08/26/2008, radiology report 08/05/2008, note 07/09/2008, 06/25/2008, 01/31/2008, 11/05/2007, 07/20/2007, lab 06/27/2007, note 06/29/2007, 06/08/2007, radiology report 06/01/2007, note 05/29/2007, 05/24/2007, US 05/04/2007, radiology report 05/03/2007, note 05/03/2007, lab 03/09/2007, note 02/13/2007, 09/26/2006, 08/01/2006, 07/18/2006, procedure note 11/02/2005, impairment eval 07/26/2005, TDI form 0726/2005, letter 06/20/2005, procedure note 04/15/2005, note 04/20/2005, 03/23/2005, radiology report 01/14/2005
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**



## 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



This patient appears that he has had a very long history of low back and leg pain. He has been treated non-operatively with multiple injections and physical therapy. Imaging studies have included an MRI scan in 2005, another MRI scan in 2008, and plain x-rays in 2009. These have not been diagnostic. EMGs have been carried out in the past. These show only insertional activity suggesting a left S1 radiculopathy.

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

Using the Official Disability Guidelines, this patient is not a candidate for a myelogram and post myelogram CT. He has had previous MRI scans. He has not had previous surgery. He does not have a fracture. The records reviewed do not support the medical necessity of the request. The previous adverse determination 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
- 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
- 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)