



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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**DATE OF REVIEW: 08/18/2011**

**IRO CASE #:**

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

Lumbar MRI (72148)

### **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 to Medwork 08/01/2011
2. Notice of assignment to URA 08/01/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 07/29/2011
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/19/2011
6. Emails from CNA: email #1 100 pgs & Carrier Submission 10 pgs; email #2 100 pgs; email #3 100 pgs; email #4 100 pgs; email #5 100 pgs; email #6 64 pgs; email #7 ODG 437 pgs & ODG 374 pgs; Fax from claimant 08/08/2011 7 pgs; Fax from Rehab Therapy 15 pgs, ODG guidelines were provided by the URA

### **PATIENT CLINICAL HISTORY:**

Patient has an injury date of xx/xx/xx. Patient has a history of low back pain that radiates into the right leg and toes for many years. Patient's pain is 5 on a scale of 0-10. On physical exam there is tenderness in the low back. Patient has been treated in the past with epidural steroid injections, medications, physical therapy, and facet blocks. The patient at this time is on Vicodin. The patient's last MRI is from March 2, 2009—two-and-a-half years ago. This showed a disk protrusion at L4-L5. The physician now is recommending a surgical consultation to decide whether or not the patient needs surgery and also states at this time that the patient needs an updated MRI for this determination. A review has been requested for lumbar MRI (72148).

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



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Referring to the Official Disability Guidelines' chapter on pain under MRI, it states that patients with persistent pain for greater than a certain amount of time are allowed to have MRI scans. The review records indicate that the patient's MRI is for preoperative purposes and to decide whether or not the patient meets the criteria for this. In review of the records the requested lumbar MRI (72148) is in support of the ODG guideline recommendations; therefore, the insurer's decision to deny is 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 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)