



Medwork Independent Review

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

Date: December 8, 2011

DATE OF REVIEW: 12/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the repeat lumbar MRI deemed medically necessary for this patient?

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 [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 11/28/2011
2. Notice of assignment to URA 11/23/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 11/23/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/23/2011
6. Medicals 11/21/2011, letters from physician 11/17/2011, follow-up letter from pain center 11/12/2011, letter from workers comp 10/31/2011, MRI information 10/24/2011, letter from physician 10/10/2011, letter from workers comp 09/21/2011, medicals 09/15/2011, MRI information 09/15/2011, letter from physician 09/12/2011, follow up report 08/30/2011, medicals 08/30/2011, medical report 08/23/2011, medicals 07/26/2011, 06/03/2011, evaluation letter 04/05/2011, MRI information 12/08/2010, medicals 09/01/2010, 08/23/2010, 08/16/2010, 08/15/2010, 07/14/2009, , evaluations 08/25/2008.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY



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The patient is a male who was injured on xx/xx/xx. The patient has ongoing level 7/10 subjective constant lumbar throbbing and sharp pains. Exam findings were documented to reveal restricted range of motion of the lumbar spine. There was felt to be sensory loss at L4-L5 level on the right side and positive bilateral straight leg raises, pending MRI for surgery per Dr.. The patient had been reevaluated and was having ongoing back pain with bilateral leg radiation. Exam findings revealed decreased range of motion and ongoing grade 4/5 weakness in the tibialis anterior bilaterally. Reflexes were noted to be normal. An MRI to assist in the decision-making process regarding treatment options was felt medically necessary per that provider.

Within the medical records, it was noted that the patient had been previously treated with bilateral epidural steroid injections as of April 2011. There were prior MRI scans on October 10, 2008; July 14, 2009; and December 8, 2010; most recently revealing a "disk herniation at L4-L5 with flattening of the thecal sac and disk herniation at L5-S1 with mild hypertrophic facet arthropathy..." Electrodiagnostics from March 17, 2011, were noted to reveal lumbar radiculopathy on the left and right at L5. Prior study was noted to have been dated August 25, 2008.

The patient was also noted to have been treated with chiropractic and physical therapy. The patient was noted to have had a psychological evaluation on April 5, 2011, "consistent with major depression and pain disorder with psychological and medical factors. Recommended medications and six outpatient psychology sessions..."

There was insufficient evidence of a significant change in symptoms and/or findings suggestive of significant pathology. There are no medical reports that documents exhaustion and failure of conservative treatment such as activity modification, home exercise training, oral pharmacology, and physical therapy...there are no noted VAS pain scales in physical therapy notes documenting a lack of progress in several attempts...

Reviewing the medical documents, the patient had failed non-operative management and warranted an updated MRI scan. Reference was made to the ongoing back pain with radiation down the legs, positive straight leg raising, sciatic notch tenderness, and ongoing bilateral anterior tibialis weakness.

There were documents from Dr. as of August 30, 2011, which documented herniated disks at L4-L5 and L5-S1 with ongoing subjective and objective findings and a consideration for a second opinion regarding surgical intervention. Prior records included chiropractic notes as of the summer of 2010. The prior records from Texas Anesthesia Back Center were also referenced. The prior chiropractic records were also reviewed. The MRI from July 14, 2009, report revealed a disk bulge, L4-L5, right, posterolateral, with narrowing in the right lateral recess and central canal, and an L3-L4 posterolateral left-sided disk bulge with L5-S1 being normal.



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

The applicable *Official Disability Guidelines* would support a repeat MRI typically only if there has been a significant clinical change in the individual's neurologic status and/or postsurgical intervention. There has not been recent documentation of any significant change in the subjective and/or objective findings. The prior MRI scans appear to correlate with the current symptoms and exam abnormalities. The evidence of a provision of medications and other forms of comprehensive non-operative treatment, including therapy and detailed response to same, has not been provided. Therefore, a repeat MRI is not deemed medically necessary per the *Official Disability Guidelines*.

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)