



Medwork Independent Review

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

01/04/2011

DATE OF REVIEW: 01/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI lumbar spine with gadolinium

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 12/20/2010
2. Notice of assignment to URA 12/20/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 12/17/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/15/2010
6. Letter 12/23/2010, review 12/08/2010, 11/18/2010, Medicals 11/09/2010, 11/04/2010, 09/28/2010, 09/17/2010, 09/14/2010, 09/07/2010, 08/31/2010, 08/24/2010, 07/26/2010, FCE 06/29/2010, medicals 06/21/2010, 06/15/2010, 06/07/2010, 05/18/2010, 05/17/2010, 04/02/2010, 01/12/2010, 12/10/2009, 11/24/2009, 10/13/2009, 10/13/2009, 09/22/2009, 06/09/2009, 05/12/2009.



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7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

The patient sustained injury on xx/xx/xx. Patient had a prior history of low back disorder. He had been treated with a prior laminectomy at the L5-S1 level prior to the accident of xx/xx/xx. Following the accident of xx/xx/xx, there is no documentation of any radicular complaint. There specifically is no documentation of any nerve retention signs. There is no documentation of any motor weakness in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus, or gastrocnemius and soleus group. Review request is for MRI lumbar spine with Gadolinium.

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

Using Official Disability Guidelines along with the submitted review records, there is no progressive neurologic deficit documented that would suggest that the requested MRI lumbar spine with gadolinium is necessary; therefore, the insurer's denial 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)