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

DATE OF REVIEW: 06/01/2011
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
MRI of Lumbar Spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Occupational Medicine 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. IRO Assignment 05/13/2011,
2. Notice of assignment to URA 05/13/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 05/13/2011,
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 05/12/2011,
6. Adverse Determination Letters 05/09/2011, 03/25/2011, 01/19/2011, Physician letter 05/05/2011, Medicals 04/25/2011, 03/28/2011, 03/22/2011, 03/21/2011, 02/28/2011, 01/31/2011, 01/25/2011, 09/07/2010, 08/24/2010, 08/04/2010, 04/20/2010, 11/05/2009, 10/21/2009, 09/24/2009, 09/09/2009, 08/19/2009, 02/11/2008.
7. ODG guidelines were not provided by the URA,

PATIENT CLINICAL HISTORY:
This is a XX-year-old man with history of chronic neck and back pain due to a work-related injury on XX/XX/XX. The patient had a MRI of the lumbar spine in February of 2008, which revealed 2.0 mm right paracentral disc bulge with central foraminal stenosis. The patient was treated with medication and physical therapy, which did not provide him lasting relief. He continued to complain of low back pain with radiation to his left lower extremity. There was evidence of radiculopathy on his examination (positive left straight leg and depressed left ankle reflex). The patient underwent 2nd MRI of the lumbar spine for re-evaluation in October of 2009. The test revealed a broad-based central disc herniation at L5-S1 measuring approximately 4-5 mm with associated annular tear. He was continued to be treated conservatively; his clinical condition, however, mostly stayed unchanged. On his last follow-

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up, the patient reported ongoing pain in his back radiating all the way down to his left leg and foot. On examination, he was noted to have restriction of range of motion, positive straight leg sign, mildly decreased muscle strength in the left leg and depressed left ankle reflex. Review request is for MRI of the lumbar spine.

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

Official Disability Guidelines state: "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)". "Subsequent imaging should be based on new symptoms or changes in current symptoms". This patient has history of neck and back pain for more than 03 years. Based on clinical evaluations and two MRI tests, he has been diagnosed with lumbar herniated disc disease with evidence of radiculopathy. There has not been any gross change in his clinical findings since his last MRI in October of 2009. In review of the ODG recommendations and records submitted, in the absence of significant change in this patient's clinical condition, such as progression of any neurologic deficit or appearance of other "red flag signs", the insurer's decision to deny the requested MRI lumbar spine 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)**