



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



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

**Amended Date: November 16, 2011**

**Date: November 10, 2011**

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 11/10/2011**

**IRO CASE #:**

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

Is the MRI, spinal canal and contents, lumbar; without contrast materials considered 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. Assignment to 11/03/2011
2. Notice of assignment to URA 09/27/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 11/02/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 09/28/2011
6. Letter from Insurance 11/03/2011, 09/21/2011, Letter from physician 09/21/2011, Insurance Letter 09/19/2011, Preauthorization Request 09/16/2011, Insurance Letter 09/13/2011, Medicals 09/13/2011, 09/07/2011, 09/01/2011, 08/31/2011, 08/15/2011, 08/11/2011.
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

The patient is a male with a date of injury of xx/xx/xx. The patient has been evaluated and treated primarily by. As of August 11, 2011, one day after the date of injury, there were



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complaints in the ribs; fingers; and cervical, thoracic, and lumbar spine. The injury mechanism was that the patient had fallen.

The objective findings were noted to not discuss any particular spinal-related abnormalities. Diagnoses, however, were noted to include sprain; strain; and myospasm of the cervical, thoracic, and lumbosacral areas. The follow-up with the same provider revealed, on August 15, 2011, "vague musculoskeletal complaints." X-rays of the cervical and lumbar spine were noted to have been read as normal. Off-work status continued.

A follow-up two weeks later on September 1, 2011, discussed that the patient had been evaluated by There had been a consideration for a cervical MRI. The claimant reportedly indicated by history to that there were some complaints of pain from the right shoulder and into the right upper extremity. There was noted to be some slightly reduced cervical range of motion overall. There were no deficits documented of the upper extremities. Diagnoses included neck pain with radicular-type pain involving the right upper extremity. Cervical, thoracic, and lumbar spine MRI scans were prescribed.

The next set of records reviewed included the notes documenting an off-work status in the summer of 2011 as per. The re-review of the entirety of the documentation from discussed subjective complaints at the level of the thoracic and lumbar spine. The patient's weight was noted to be 305 pounds with regard to the musculoskeletal system. There were no objective findings documented with regard to the lumbar spine in particular at all. The neurological examination was not noted to be normal or abnormal with regard to the lower extremities per the entirety of the examinations.

Denial letters have been reviewed with rationale being the lack of objective findings at the level of the lumbar spine and the lack of documented neurologic deficit regarding the lumbar spine or lower extremities, in addition to the lack of documentation of a comprehensive trial of conservative treatment, including medication therapy.

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

The submitted documentation does not, as per clinically applicable Official Disability Guidelines, evidence that there is a medical necessity for the requested lumbar spine MRI. In particular, the specific rationale for this opinion is that the lumbar spine, MRI indications as per the Official Disability Guidelines, reveals that there would typically need to be a history of significant lumbar spine trauma with neurologic deficit. In addition, there would typically have to be low back pain with radiculopathy "after at least 1 month of conservative therapy, sooner if severe progressive neurologic deficit." The patient does not have a documented neurologic deficit, a history of severe trauma, and, in fact, there were no objective findings even documented regarding the lumbar spine, including any evidence of neurologic abnormalities. There are no subjective findings or objective findings for that matter compatible with "cauda equina syndrome," either. Therefore, applicable Official Disability Guidelines criteria have not



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at all been met with regard to the submitted request for lumbar MRI. The lumbar MRI would not be, therefore, considered medically reasonable or necessary at this time based on applicable clinical guidelines and this reviewer's clinical experience.

### **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)