



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 2/3/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat lumbar MRI with and without contrast.

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

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.

PATIENT CLINICAL HISTORY:

The claimant has been documented to be a individual who was injured xx/xxxx. Despite treatment, the claimant continued to report pain in the bilateral lower extremities, including the thighs. The claimant also reported ongoing numbness and tingling in the similar distribution, most recent exam and findings revealed intact sensation, although there was a painful low back motion. Ongoing treatments have included medications. There has been consideration for a repeat diagnostic. Specifically the claimant has been noted in detailed as on 10/22/2014 to have persistent back pain with the aforementioned lower extremity radiation. It also has been noted that the deep tendon reflexes have been intact. Medications have included Lyrica and Flexeril and a topical analgesic. The prior MRI report from 01/23/2014 had included lumbar scoliosis along with disc abnormalities at multiple levels of the lumbar spine, along with disc space narrowing.

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

Without documentation of severe and progressive neurologic deficit and without a recent comprehensive trial and failure of documented conservative treatment, the applicable ODG guideline criteria for a repeat lumbar MRI had not been met. The claimant has not had any significant documentation of motor, sensory or reflex abnormalities and no severe progression of any neurologic abnormalities, and the patient is not noted to be in a postoperative state. Therefore the ODG guideline criteria have not been met for a repeat MRI with and without contrast at this time.



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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)