



Medwork Independent Review

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DATE OF REVIEW: 10/01/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 Decompression w/Fusion and 6 days inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Texas State Licensed MD Board Certified Orthopaedic 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 09/20/2007
2. Texas Dept of Insurance Notice of Assignment to Utilization Review Agent 09/20/2007
3. Confirmation of Receipt of a Request for a Review by an IRO 09/19/2007
4. Company Request for IRO Sections 1-8 undated
5. Request for a Review By an IRO 09/18/2007
6. Reconsideration Determination 09/06/2007
7. Notification of Initial Determination 08/03/2007
8. Utilization Review Referral 5 follow up office visits 09/13/2007
9. Utilization Review Referral L5-S1 Decompression w/Fusion and 6 days inpatient stay 08/24/2007
10. Office note 08/13/2007
11. Utilization Review Referral L5-S1 Decompression w/Fusion 09/13/2007
12. Office note 04/02/2007; 05/09/2007; 06/15/2007; 07/23/2007
13. Patient Diagnostic Report for CT lumbar spine w/contrast 03/21/2007
14. Patient Diagnostic Report for lumbar discography 03/21/2007
15. Operative Report/Procedure L4-5 lumbar discogram and L5-S1 lumbar discogram 03/21/2007
16. History and Physical 03/21/2007
17. Office note 02/19/2007
18. Utilization Review Referral L4-S1 lumbar discogram 02/15/2007
19. Utilization Review Referral Selective endoscopic discectomy w/anuloplasty 02/15/2007



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20. Utilization Review Referral Selective endoscopic discectomy w/anuloplasty undated
21. Office note 01/03/2007
22. CT Post discogram lumbar spine report 12/08/2006
23. Pre-Authorization Request form for lumbar discogram undated
24. Office note 10/27/2006
25. MRI lumbar spine without contrast report 06/20/2006

PATIENT CLINICAL HISTORY: [SUMMARY - REFRAIN FROM USING NAME]

This patient presented with an increasing history of low back and right leg pain. Symptoms started on xx/xx/xx. She began physical therapy. This did not help. She underwent three epidural steroid injections. This did not provide her with ongoing benefit.

She was assessed by Dr. on October 27, 2006. At that time, it was noted that she had normal Achilles reflexes. At that time, it was noted that she had 5/5 power in the gastroc and soleus group bilaterally.

I have reviewed the MR scan report dated 06/20/2006. There is no evidence of any nerve root compression on that report.

She subsequently underwent CT diskograms.

These were undertaken on December 8, 2006. The lumbar diskogram at L5-S1 noted a right paracentral herniation with some foraminal stenosis.

The patient was recommended to have an endoscopic procedure. This was denied. She has now been recommended to have a discectomy and fusion.

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

In my opinion, it is unreasonable to approve a posterior L5-S1 decompression and fusion with six-day inpatient stay.

There is no evidence that the patient would benefit from the aforementioned surgery. This is based upon the ODG criteria as well as numerous other publications including the Gibson-Cochran references, Deyo references, and the AANS/NASS Guidelines.

I would note that there is no indication that this patient has a spondylolysis or a spondylolisthesis. This was not reported in any of the imaging studies. At was with some surprise that I noted it in the assessment of Dr. on August 13, 2007. It is my opinion that the previous adverse determination should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:



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- 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)