



Medwork Independent Review

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

12/01/2008

DATE OF REVIEW: 12/01/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar L3-S1 with and without lateral transverse each additional vertebral segment athrodesis posterior interbody laminectomy/discetomy posterior segmental instrumentation with 3-4 days LOS 22612, 22614, 22630, 22632, 22842, 22851 to be complete by 12/12/2008

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 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 11/12/2008
2. Texas Dept of Insurance notice of assignment of IRO 11/12/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 11/10/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 11/07/2008
6. preauth determination appeal 10/30/2008
7. preauth determination 10/27/2008
8. Preauth request 10/21/2008
9. Function Pain Center exam 10/20/2008
10. Office note 10/10/2008, 08/01/2008, 05/02/2008
11. Discogram findings 10/02/2008
12. Lumbar spine views 05/14/2008, Addendum radiology report 05/19/2008
13. MRI lumbar spine w/o contrast 07/09/2007



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14. Pain Management Clinic of undated history sheet
15. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Patient has a work related injury from xx/xx/xx involving the lower and upper back. Patient's physician has recommended a lumbar L3-S1 with and without lateral transverse each additional vertebral segment athrodesis posterior interbody laminectomy/discetomy posterior segmental instrumentation with 3-4 days length of stay.

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

Flexion/extension films have not shown any evidence of instability. For this reason, surgery would not be successful. The patient has had MR scanning, which only showed central bulging at the L4-5 and L5-S1 levels. This in of itself is insufficient to recommend surgery. Discography was carried out and all three levels that were evaluated were shown to be abnormal. There is no control. Using the ODG guidelines and using medical judgment and clinical experience, 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:

- 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)