



Medwork Independent Review

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

02/25/2008

DATE OF REVIEW: 02/25/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient spinal surgery LOS 2-3, 22558, 22585, 64999, 22851, 63047, 63048, 22612, and 22614, L0637

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 02/07/2008
2. Notice to URA of assignment of IRO
3. Confirmation of Receipt of a Request for a Review by an IRO 02/06/2008
4. Company Request for IRO Sections 1-8
5. Request For a Review by an IRO patient request 02/05/2008
6. letter Utilization Review Decision 01/31/2008
7. letter Utilization Review Decision 01/15/2008
8. Request for preauthorization for surgery 01/06/2008
9. letter Notification of Determination 07/17/2007
10. Prior Authorization Request 02/12/2007
11. Listing of patients providers



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12. Psychological Eval 11/20/2007
13. Chart note 11/07/2007; 02/08/2007; 02/05/2007; CT & OP report 11/20/2006; 10/02/2006; 08/08/2006; 05/30/2006; CT 05/26/2006; Radiology Consult 04/19/2006; 04/12/2006; 11/26/2005; 06/27/2005; 02/03/2005
14. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient was involved in an accident on xx/xx/xx. She has been treated with pain management by Dr.. I should note that she has had bilateral facet joint blocks and epidural steroid injections. She has further had radiofrequency thermal coagulation. Despite all these investigations, she has only had up to 10% relief of her pain. This has not been long-standing. I call your attention to the MRI carried out on May 26, 2006. There was loss of signal intensity throughout the disks of the lumbar spine. There were extradural defects at L1-2, L2-3, L4-5, and L5-S1. I also call your attention to the discography carried out on November 20, 2006. There was only provocation of pain at the L5-S1 level. The post-discogram CT showed a paracentral protrusion at L2-3, an annular tear at L4-5, and insufficient contrast to determine the morphology at L5-S1. There are no flexion and extension films.

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

Using the guidelines of the American College of Occupational and Environmental Medicine UM Knowledge Base and the Official Disability Guidelines and Treatment Guidelines, it is my opinion that the previous adverse determination for spinal surgery should be upheld. Specifically, there is no objective evidence of spinal instability. There is insufficient data to identify the L4-5 and L5-S1 levels as being isolated pain generators. In addition, discography and MR scanning is abnormal at adjacent levels.

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



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- 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)**