



## Medwork Independent Review

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

**06/25/2008**

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 06/25/2008**

**IRO CASE #:**

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

Lumbar laminectomy/discectomy at levels L4-5, L5-S1 with instrumentation L5-S1, L4-5 plus lateral fusion L4-5, L5-S1 plus bone growth stimulator implantation/ with 3 day IP LOS

**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.

**PATIENT CLINICAL HISTORY:**

This gentleman was originally injured on xx/xx/xx. He was demonstrated to have disk herniations at L4-5 and L5-S1. He underwent surgery on May 15, 2007. Postoperatively, he did not do well. He continued to have significant symptoms.

An MR scan was carried out on January 30, 2008. This showed normal anatomic alignment and lumbar spine. An annular disk bulge flattens the thecal sac at L3-4. At L4-5, his postoperative scar which encircles the thecal sac as well as the L-5 nerve root sleeves. There is a recurrent 5 mm right subarticular disk herniation with annular tear.

At L5-S1, there has been a laminectomy, and again, there is a postoperative scar noted dorsal to the thecal sac abutting the right S-1 nerve root.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS.**



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### **FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

In my opinion, using the ODG Guidelines, this patient is not a candidate for a lumbar fusion. There is no evidence of instability on flexion and extension films. The adjacent L3-4 level to the proposed surgery is demonstrated to be abnormal on MR scan. This patient has marked epidural scarring. This is not an entity which is treated surgically. In my opinion, 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 KNOWLEDGBASE
- 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



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**FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**