Medwork Independent Review
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Eau Claire, Wisconsin 54703
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: **05/20/2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
1) L4-5, L5-S1 ALIF with posterior decompression and stabilization (22558, 22585, 22612, 22842, 22614, 22851x2, 22845, 63047, 20902, 63090, 63091, 77001, 20938, 63048, 69990) with 3 day in-patient stay; 2) Osteogen Stim (E0748)

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 is a XX-year-old male who sustained injury on XX/XX/XX. The patient subsequently underwent MR scanning in March of 2007. At that time, it was noted that he had a right-sided disk herniation at L5-S1 and central disk herniation at L4-5. The patient was noted to have a radiculopathy. EMGs confirmed radiculopathy.
It was noted that this patient had demonstrable weakness in the hamstrings in the examination of May 25, 2007.
I reviewed the report of the discograms carried out on November 29, 2007. At that time, the L3-4 disk was completely normal with no evidence of any tear. There was no provocation of any pain. At L4-5 and L5-S1, there was derangement of the disk with annular tearing and provocation of concordant pain. The patient has stopped smoking. The patient has had blood work to confirm that. The patient has had a psychiatric evaluation and has been found to have no contraindication to surgery. The treating doctor had confirmed that there is motion on flexion extension films.

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

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In my opinion, this patient fills all the criteria for surgery as defined by the ODG Guidelines. In my opinion, medical judgment, clinical experience, and expertise in accordance with accepted medical standards, this patient is a reasonable candidate for the services in dispute.

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)**