



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)

11/03/2008

DATE OF REVIEW: 11/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior cervical discectomy with fusion and plating at C5-6 with 1 day 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 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. Assignment to 10/20/2008
2. notice to URA of assignment of IRO 10/20/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 10/17/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/16/2008
6. appeal denial letter 10/06/2008
7. Preauth request fax cover 09/29/2008
8. denial by physician advisor letter 09/16/2008
9. Preauth request fax cover 09/11/2008
10. note 09/25/2008, 09/08/2008
11. OP report 08/15/2008
12. radiology report (myelogram, two or more reg & CT L-Spine w contrast) 08/15/2008
13. note 08/07/2008
14. OP report 06/12/2008, 03/27/2008
15. Office visit 11/15/2007
16. Q&S Pain Management note 09/26/2007
17. report 09/13/2007



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



18. MRI of LLC 09/05/2007
19. patient record 06/06/2007
20. Office note 05/21/2007
21. CT 05/30/2007
22. Note 04/17/2007
23. Initial Evaluation Note 04/05/0007
24. Radiology Exam Report MRI cervical spine & Head 03/13/2007
25. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This individual was involved in an accident on xx/xx/xx. The patient has been having bilateral arm pain worse on the right than on the left. The patient had been investigated with MRI scanning, myelogram, and CT scanning. The report of the post-myelogram C, there is mild disk space narrowing at all levels. There is spondylyotic changes. There is some mild neural foraminal narrowing on the right at C3-4 and C5-6. There is no central canal stenosis. Specifically, there is no indication that there is any distinct nerve root compression.

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

Examination of August 7, 2008, at that time, it was noted that his right triceps reflexes could not be tested because of the bandage on his arm and the swelling. There was no description of any distinct weakness. The previous adverse determination should be upheld as per the ODG guidelines.

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



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
medworkiro@charterinternet.com
www.medwork.org



- 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)**