



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

10/15/2008

DATE OF REVIEW: 10/15/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Fusion at L4/5; 3 overnight inpt stay; external bone growth stimulator purchase; lumbar brace

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/American Board of Spine Surgery

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 09/29/2008
2. notice of assignment of IRO 09/29/2008
3. notice to URA of assignment of IRO 09/29/2008
4. Confirmation of Receipt of a Request for a Review by an IRO 09/29/2008
5. Company Request for IRO Sections 1-8 undated
6. Request For a Review by an IRO patient request 09/25/2008
7. . preauthorization request sheet (procedure & ext bone growth stim & Brace)
8. determination of reconsideration request letter 09/25/2008
9. determination of certification request letter 09/05/2008
10. Office note & medical conference note 09/23/2008
11. Letter of appeal from MD 09/17/2008
12. Office note 08/26/2008
13. exam/procedure note 08/01/2008
14. Office note 07/25/2008
15. exam/procedure note 07/18/2008
16. Chart note 07/02/2008
17. Office note 06/30/2008, 06/18/2008



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18. DNI lumbar –spine X-Ray report 06/09/2008
19. Chart note 06/09/2008
20. Chronic Pain Evaluation 05/30/2008
21. DNI CT lumbar spine including contrast & Addendum Report 04/21/2008
22. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This individual sustained an injury on xx/xx/xx. Subsequently, the patient had leg pain. He underwent a discectomy. Initially, the patient did do well with relief of the left leg pain. Subsequently, the patient developed recurrent pain, mostly in the back and down the leg. A CT scan was carried out on April 12, 2008. A left-sided L4-5 laminectomy and partial medial facetectomy is noted. The vacuum phenomenon in the disk substance is noted. Specifically, there is disk material that extends beyond the midline over to the right side. The attending physician has requested approval for surgery in the form of redo discectomy and fusion.

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

Using ODG Guidelines and using medical judgment and clinical experience, surgery would be indicated for this individual. The patient has been demonstrated to have radicular findings with EHL weakness. There is collapse of the L4-5 motion segment with vacuum phenomenon. There has already been a partial facetectomy on one side, and in order to relieve symptoms, this would probably require facetectomy on the other side. The previous adverse determination should be overturned; this man is a reasonable candidate for surgery in the form of a redo discectomy and fusion; three overnight inpatient stay; external bone growth stimulator purchase & lumbar brace.

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



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- 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)**