

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

08/25/2009

Amended 08/27/2009

DATE OF REVIEW: 08/25/2009

Amended: 08/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy with fusion and instrumentation @ L2-3, L3-4 with one night hospital 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/Spine 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 08/05/2009
2. Notice of assignment to URA 08/05/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 08/05/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/30/2009
6. determination letter 08/04/2009, 07/22/2009, 06/17/2009
7. Professional Review 08/04/2009, 07/22/2009
8. Auth request fax cover sheet 07/17/2009
9. Medical note 07/03 & 07/2009, OP report 07/01/2009, 06/22/2009, 06/11/2009, OP report 06/03/2009, radiology reports 06/03/2009, 05/21/2009, 02/26/2009, 12/29/2008, post-op spine lumbar report 12/29/2008, 10/27/2008, 08/11/2008, discharge report 07/24/2008, op report 07/23/2008, H&P 07/23/2008, 07/17/2008, 06/16/2008
10. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The patient has previously undergone surgery. In the past, the patient has undergone an L5-S1 decompression and fusion. The patient has undergone an L4-L5 decompression and fusion. The patient has been demonstrated to have stenosis at the L2-L3 and L3-L4 levels. The patient apparently had some radicular complaints. There is nerve root deficit identified.

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

Using the Official Disability Guidelines and the provided medical documentation, this patient does not fulfill criteria for fusion either at L2-L3 or at L3-L4. There is no demonstration that the patient has any segmental instability. There is no demonstration of hypermobility on flexion/extension films. 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)