

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

DATE OF REVIEW: 02/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior lumbar interbody fusion at L4-5 & L5-S1, post lumbar decompression w posterolateral fusion & pedicle screw instrumentation at L4-5 & L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopedic Surgeon & American Board of Spine Surgery physician

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 02/11/2009
2. Texas Dept of Insurance notice of assignment of IRO 02/11/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 02/11/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 02/10/2009
6. Letter from 02/02/2009
7. MRI lumbar spine 01/29/2009
8. Follow up note 01/26/2009
9. reconsideration/appeal of adverse determination letter 01/15/2009
10. PA request undated
11. Letter from 01/06/2009
12. Patient information sheet undated
13. Lumbosacral spine series, seven views 12/31/2008
14. utilization review determination letter 12/29/2008
15. Pre surgical screening behavior health evaluation 12/17/2008
16. Follow up note 11/24/2008
17. fax cover sheet 10/21/2008
18. letter 09/15/2008
19. review decision 09/11/2008
20. reconsideration/appeal of adverse determination letter 08/16/2008
21. request for lumbar discogram w post discographic CT to be presented for medical dispute resolution 08/14/2008, 08/18/2008
22. Preauthorization request for a lumbar discogram w discographic CT reconsideration 07/22/2008

23. Consultation 05/19/2008
24. Report of medical evaluation 04/30/2008
25. Review of medical history & physical exam 04/30/2008
26. Follow up note 03/12/2008
27. Pain evaluation 02/27/2008
28. Preauthorization letter 01/30/2008
29. Procedure note 01/24/2008
30. Follow up note 01/16/2008
31. Orthopedic referral sheet 01/09/2008
32. Lumbar and cervical myelogram 01/03/2008
33. Post myelogram CT cervical spine& lumbar spine 01/03/2008
34. Office note 12/05/2007, 11/27/2007
35. Electrophysiological evaluation 11/08/2007
36. Follow up note 11/05/2007
37. Letter from 11/02/2007
38. Procedure note 10/22/2007
39. Letter from 10/10/2007
40. Procedure note 09/24/2007
41. Follow up note 09/12/2007
42. Procedure note 09/07/2007
43. MRI lumbar spine w/o contrast & cervical spine w/o contrast 08/23/2007
44. Initial medical narrative 08/01/2007
45. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This individual was involved in accident on xx/xx/xx. The patient had previous surgery. Multiple attempts have been made at nonoperative management. These attempts have included physical therapy, epidural steroid injection, and facet blocks.

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

The patient has neurologic symptoms. The patient has been demonstrated to have neurologic findings. EMGs have been carried out, and these are positive, confirming lumbar radiculopathy. The patient has had an MR scan, a myelogram, CAT scan, and a more recent MRI dated January 29, 2009. This does demonstrate spondylolisthesis at L5-S1. Previous laminectomies have been identified. There is evidence of signal change at L4-L5 and L5-S1 with multiple small annular tears. Instability has been confirmed on flexion-extension films. This patient fulfills the Official Disability Guidelines for a lumbar fusion. The previous adverse determination should be overturned. The patient has failed nonoperative management. There is good description and confirmation of neurologic involvement, as well as significant annular tearing and signal changes in the disks at L4-L5 and L5-S1, together with instability.

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)