

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

**01/22/2009**

**DATE OF REVIEW: 01/22/2009**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Posterior laminectomy/foraminotomy at L5-S1 w 1 day inpt 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 Medwork 01/05/2009
2. notice of assignment of IRO 01/05/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 01/02/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/31/2008
6. letter 01/06/2009
7. reconsideration denial letter 12/15/2008
8. preauthorization denial letter 12/03/2008
9. Fax cover sheet preauthorization request 11/26/2008
10. Notice of Independent Review Decision 10/01/2008
11. notice of disputed issues and refusal to pay benefits 09/04/2008
12. Preauthorization fax cover 11/25/2008
13. office note 11/10/2008
14. discogram lumbar spine 10/31/2008
15. CT lumbar spine 10/31/2008
16. office note 10/14/2008
17. chronic pain management program interview 08/14/2008
18. note 08/04/2008, 07/28/2008
19. radiology report 07/24/2008
20. CT lumbar myelogram w contrast 07/24/2008
21. Lumbar myelogram 07/24/2008
22. office note 07/02/2008
23. Office note 06/23/2008, 06/22/2008
24. electrodiagnostic study 05/23/2008

25. note 05/15/2008
26. report 01/17/2007
27. Radiology report 01/17/2007
28. report 10/24/2006
29. Radiographic procedure report 10/24/2006
30. MRI of lumbar spine w/o contrast 05/02/2005
31. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This individual was involved in an accident on xx/xx/xx. He has subsequently been treated with a variety of medications, physical therapy, facet injections, rhizotomy, and sacroiliac joint injections. In the past he has responded both to rhizotomies and to sacroiliac joint injections.

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

The medical record dated November 10, 2008; at that time it was recommended that this man consider an L5-S1 foraminotomy to decompress the left L5 nerve root. This is in distinct difference to the medical record dated August 4, 2008. In that record the attending physician that he had had an opportunity to review myelogram and post-myelogram CT. He indicated that the only positive feature was a conjoined nerve root on the right at L5-S1. Obviously that was clinically insignificant, since this man's pain is on the left side. At that time, medical record indicated that the patient clearly described an S1 radiculopathy. This is in contradistinction to an EMG, which shows a left L5 radiculopathy. In addition, the attending physician indicates that the facet articulation on the patient's right is distinctly different on the right, which is the asymptomatic side. In the date of service August 4, 2008, it was recommended that discograms be carried out in order to garner further information, presumably to determine whether there was a discogenic source of this man's pain, which could be effectively treated surgically. Discograms have subsequently been carried out and have been found to be negative. Therefore, the discograms did not add substantially to the understanding of this man's etiology of his pain. There is contradictory information on the studies presented and due to this deficient information the decision is upheld 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

- 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)