



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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www.medwork.org



### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*

**DATE OF REVIEW: 11/18/2009**

**IRO CASE #:**

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

Prodisc @ L4-5 & mini 360 @ L5-S1 with 2 day LOS (22857, 63090, 22558, 22851, 20931, 22612, 63047, 20931, 95920, 22842)

**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 Medwork 10/30/2009
2. Notice of assignment to URA 10/30/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 10/29/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/28/2009
6. letter 10/22/2009, 10/13/2009
7. Pre-auth 10/08/2009, medical note 09/29/2009, scheduling 09/28/2009, pt info sheet, injured worker sheet, MRI 09/22/2009, medical note 09/08/2009, radiology report 09/08/2009, medical note 07/28/2009, 06/30/2009, op report 06/22/2009, CPMP report 06/15/2009, medical note 04/14/2009, 02/24/2009, designated doctor exam 01/22/2009, TDI form 01/07/2009, medical note 09/23/2008, 08/26/2008, 08/12/2008, 07/29/2008, radiology report 07/29/2008, MRI 07/21/2008
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This patient had an injury on xx/xx/xx. The patient had previously had L4-L5 lumbar surgery in 2001. On June 22, 2009, the patient was taken to the operating room for a left L4-L5 revision hemilaminectomy. There was epidural fibrosis and lysis of adhesions was carried out. There was an incidental durotomy. This was repaired. At that time, a left L5-S1 hemilaminectomy with decompression of the left S1 nerve root was also carried out. Unfortunately, the patient has continued to have pain. This is low back pain radiating into the left leg. The patient has undergone an MRI scan dated September 22, 2009. The neuroradiologist has indicated a large,



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1-cm, left paracentral disk herniation at the L4-L5 level. There is some postoperative scarring. There is a recurrent disk herniation at L4-S1 measuring 5 mm, and it effaces the left lateral recess.

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

Using the Official Disability Guidelines, the requested procedure is denied. Disc prosthesis is not recommended for either degenerative disc disease or mechanical low back pain. The reviewed documentation and the patient's condition do not support the medical necessity of the requested procedure. There is no indication that any instability has been documented and radiculopathy is an exclusion criteria for a lumbar disc replacement. The previous adverse determination is 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 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)