



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION

DATE OF REVIEW: 11/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

- 1) Re-exploration of the L3-L4 segment w/arthrodesis & transpedicular; AND
- 2) Repair of pseudomeningocele w/excision of recurrent herniated nucleus pulposus

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 11/03/2009
2. Notice of assignment to URA 11/03/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 11/02/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/22/2009
6. letter 10/02/2009, 08/31/2009, letter to the IRO 11/06/2009
7. Fax pre-auth reqst 10/21/2009, teleconference 10/01/2009, medical note 09/29/2009, 08/27/2009, teleconference 08/26/2009, fax pre-auth rqst 08/24/2009, demographics 08/24/2009, medical note 08/13/2009, radiographic 08/13/2009, CT & myelogram 07/22/2009, medical note 07/07/2009, radiographic 07/07/2009, MRI 06/15/2009, medical note 06/02/2009, radiographic 06/02/2009, discharge 05/25/2009, lumbar spine report 05/24/2009 & 05/22/2009, op report 05/22/2009, medical note 04/28/2009, addendum 04/08/2009, medical note 04/01/2009, 03/19/2009, radiographic 03/19/2009, medical note 03/12/2009, initial 02/26/2009, radiographic 02/26/2009, MR 07/08/2009
8. ODG guidelines low back lumbar & thoracic, fusion (spinal)

PATIENT CLINICAL HISTORY:

The claimant had an injury xx/xx/xx and had a right L3-4 discectomy on 05/22/2009. Patient continues to have low back pain that radiated to the right lower extremity. An exam shows probable central spinal fluid leak. MRI shows post op change on the right side of the right L4-5



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hemilaminotomy with disc herniation and moderate spinal stenosis. Lumbar myelogram shows a laminotomy defect consistent with post surgical changes. There is no documented neurological deficit, myelopathy, or cauda equine syndrome. Treatments for this patient include multiple medication trials and lumbosacral orthosis. The request is for re-exploration of the L3-L4 segment w/arthrodesis & transpedicular fixation and a repair of the pseudomeningocele w/excision of recurrent herniated nucleus pulposus.

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. The patient's condition and medical records reviewed do not support the medical necessity of this request based on the recommendations. There isn't documented instability, progressive neurologic deficit, or infection. 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 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)