



Medwork Independent Review

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

DATE OF REVIEW: 11/03/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

3 day inpt stay for anterior lumbar fusion L4-5, L5-S1 with cages; posterior lumbar fusion L4 sacrum w/hardware at Medical Center and in office Cybertech Premium Plus Brace as requested by Dr.

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 10/14/2009
2. Notice of assignment to URA 10/14/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 10/14/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/01/2009
6. Risk review 10/15/2009, letter from patient 10/02/2009, letter 09/08/2009
7. Medical note addendum 09/01/2009, letter 08/13/2009, letter from MD 08/13/2009, pre-auth reqst 08/10/2009, fax 08/06/2009, pre-cert reqst 08/04/2009, medical note 07/29/2009, XR myelo, CT T-Spine, CT cervical spine 07/14/2009, MRI L-Spine, MRI C-spine, & MRI T-Spine 07/10/2009, pre-auth 07/09/2009, medical note 07/02/2009, MRI L-Spine 07/02/2009, letter 06/30/2009, letter from MD 06/15/2009, TDI hearing notice 05/28/2009, TDI decision 05/22/2009, TDI report 03/05/2009, medical note 03/04/2009, IRO decision 03/03/2009, letter 02/20/2009, IRO Alert cover 02/16/2009, letter 02/12/2009, review 02/11/2009, pre-cert rqst 02/04/2009, letter 01/29/2009, review 01/29/2009, email 01/28/2009, fax pre-auth 01/27/2009, email 01/27/2009, review 01/27/2009, pre-auth 01/23/2009, email 01/23/2009, summaries, peer review 01/14/2009, medical letter 01/05/2009, MRI 12/29/2008, medical note 12/24/2008, EMG 12/24/2008, worker's comp verification form



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12/04/2008, MR 11/24/2008, op report 01/03/2008, health & behavioral assessment interview & testing 12/30/1998

8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

Claimant has had prior disk surgery in xxxx at the L4-L5 level. The patient had not done well with that. The patient had another accident in xx/xxxx. Since that time, the patient has had back pain. This has become associated with alterations in bowel and bladder control. There is some question about sexual function. This patient's imaging studies have shown some stenosis at L4-L5. Note the physical examination documenting normal strength in the lower extremities and normal reflexes.

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

The previous adverse determination should be upheld based on Official Disability Guidelines. In the absence of demonstrable instability, the surgery that has been recommended should not be approved. There is no indication that the patient has instability as measured on flexion-extension films. There is no indication that the patient has a spondylolisthesis.

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)