



Medwork Independent Review

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

09/09/2009

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 09/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar CT myelogram with flex 7 extension views

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. Texas Dept of Insurance Assignment to Medwork 08/24/2009
2. Notice of assignment to URA 08/24/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 08/21/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/20/2009
6. letter 08/11/2009, 07/20/2009
7. physician advisor report 08/11/2009, 07/17/2009
8. Request for reconsideration not dated, letter 08/03/2009, request for reconsideration 07/14/2009
9. DNI order 07/09/2009, medical note 07/09/2009, 05/21/2009, medical note 05/07/2009, OP report 03/17/2009, H&P 02/16/2009, medical note 01/08/2009, 10/30/2008, 07/31/2008, 03/06/2008, 02/07/2008, 01/03/2008, radiology report 12/05/2007, 11/08/2007, 09/06/2007, 06/07/2007, 03/15/2007, 01/18/2007, radiology report 05/03/2006
10. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:



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Claimant had sustained a back injury xx/xx/xx. Patient complaint is severe low back and leg pain. This patient has been documented to have an interbody and posterior fusion at the L4-L5 level. Previous X-rays flexion and extension have shown instability both at the L3-L4 and L5-S1 levels. The patient did have a CT myelogram in 2006. The requesting doctor is considering surgical treatment and is requesting an updated lumbar CT myelogram with flex 7 extension views be done to further investigate possible surgical planning as previous non-operative treatments and additional medical complaints have since been presented with this claimant.

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

The previous adverse determination should be overturned. It is medically necessary and reasonable for this individual to undergo a recent lumbar CT myelogram with flex 7 extension views. Based upon the records submitted, this patient has been documented to have an interbody and posterior fusion at the L4-L5 level. Previous X-rays flexion and extension have shown instability both at the L3-L4 and L5-S1 levels. The patient did have a CT myelogram in 2006. This is outdated. The requesting doctor is considering surgical treatment. Surgery may be required, and surgical decision-making would be made on updated lumbar CT myelogram with flex 7 extension views. Based on the ODG guidelines, this would be useful in the evaluation of this patient before consideration of surgical intervention can be determined when non-operative treatments and additional medical complaints/issues have since been presented.

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)



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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**