



## Medwork Independent Review

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

04/20/2010

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 04/20/2010**

**IRO CASE #:**

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

Ext bone growth stimulator & lumbar brace (L0637)

**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 03/31/2010
2. Notice of assignment to URA 03/31/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 03/30/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 03/29/2010
6. letter 02/18/2010, 02/05/2010
7. Pre-auth rqst, medical note 02/05/2010, 02/01/2010, radiology 01/29/2010, medical note 01/19/2010, 12/14/2009, labs 11/19/2009, eval 10/21/2009, daily note 08/11/2009, procedure note 07/01/2009, eval 06/26/2009, 04/10/2009, procedure note 04/10/2010
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This is a claimant with an injury dated xx/xx/xx. The patient has had two left L5-S1 lumbar epidural steroid injections, MRI, physical therapy and lumbar CT myelogram. It is noted in a



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previous review, dated 02/18/2010, that the patient is pre-certified for a L5-S1 fusion with 3 day in-patient stay. The patient is a known smoker. The request has been made for a brace and an external bone growth stimulator.

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

Referring to the Official Disability Guidelines, since the patient is a smoker, they fulfill the criteria for external bone growth stimulation; the previous adverse determination is overturned for the external bone growth stimulator. The Official Disability Guidelines say that bracing is under study at this time. The standard of care for a lumbar fusion, whether instrumented or uninstrumented, is to provide a brace postoperatively. This is both for protection of the instrumented and fused area as well as comfort; therefore, the previous adverse determination is overturned for the lumbar brace (L0637).

### **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)