

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

01/05/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 01/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar discogram w/ CT scan (72295, 72131, 77003, 72100, Q9967, A4550)

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 12/17/2009
2. Notice of assignment to URA 12/17/2009
3. Confirmation of Receipt of a Request for a Review by an IRO 12/17/2009
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 12/08/2009
6. letter 12/07/2009, 11/05/2009
7. Pre-auth fax rqst 11/30/2009, DNI reconsideration rqst 11/20/2009, notification of maximum medical improvement 10/27/2009, TDI form 10/13/2009, psychological eval 10/21/2009, physical exam 10/16/2009, DNI order 10/08/2009, neuro surgery consult 10/05/2009, pt face sheet 10/05/2009, office note 09/03/2009, radiology report 07/22/2009, progress notes 03/02/2009, medical note 01/30/2009, FCE 01/19/2009, EMG 08/15/2008, radiology report 06/30/2008
8. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This patient had an injury date of xx/xx/xx. He subsequently, underwent MRI scanning. An annular tear was noted at the L2-L3 level. There was noted to be desiccation of the disc with a protrusion of 5-6 mm at L3-L4. There were changes of a disc protrusion and some stenosis at L4-L5. There was desiccation of disc substance at L5-S1. The patient has subsequently undergone a myelogram and post-myelogram CT. There is noted to be a disc protrusion at the L3-L4 level. There is marked desiccation with vacuum disc phenomenon at the L4-L5 level.

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

Using the Official Disability Guidelines, the previous adverse determination is upheld. The requested lumbar discogram with CT scan would not be of value in further evaluating this patient and is not medically indicated. The patient's imaging studies thus far have shown multilevel pathology. In addition to marked degenerative changes at the L4-L5 level, there is an annular tear at L2-L3 and substantial desiccation at L3-L4 and at L5-S1 as evidenced by the MRI scan. Since he has already been demonstrated to have changes above and below the proposed L4-L5 indexed level, a fusion would not be advisable.

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)