

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

**MEDWORK INDEPENDENT REVIEW WC DECISION**

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**DATE OF REVIEW: 05/27/2010**

**IRO CASE #:**

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

L4-5 posterior decompression & revision of posterolateral fusions

**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. Assignment to 05/14/2010
2. Notice of assignment to URA 05/14/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 05/13/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 05/05/2010
6. letter 05/07/2010, review 05/05/2010
7. Pre-auth rqst 05/04/2010, letter 04/29/210, medical report 04/01/2010, test 04/01/2010, lab 01/19/2010, test 12/07/2009, medical report 12/07/2009, 10/20/2009, test 09/22/2009, medical report 09/22/2009, 06/23/2009, radiology report 04/17/2009, test 03/30/2009, medical report 03/30/2009, form 01/05/2009, fax cover 01/02/2009, medical report 10/02/2008, form 2008, review request report 07/14/2008, form 07/07/2008, medical report 07/23/2008, 04/06/2008, test 03/24/2008, medical note 03/24/2008, form 01/04/2008, test 12/17/2007, medical report 12/17/2007, form 10/04/2007, 09/20/2007, IRO decision 09/10/2007, denial letter 07/19/2007, pre-auth rqst 07/13/2007, denial letter 07/12/2007, initial letter 07/09/2007, orders 07/05/2007, test 06/25/2007, form 06/29/2007, medical note 06/25/2007, form 04/04/2007, medical report 02/14/2007, test 02/14/2007, medical report 05/11/2006, 01/31/2006, radiology report 01/23/2006, medical report 09/14/2004, 09/24/2003, 08/07/2003, 07/11/2003, TDI forms 01/06/2009, 07/08/2008, 04/06/2008, 01/08/2008, 10/09/2007, 07/10/2007, 04/10/2007
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This claimant is a male who has had three prior operations for low back pain since an injury on xx/xx/xx and continues to have complaints of pain. Procedures have included a lumbar laminectomy, an instrumented fusion from L4 - S1, and then bone grafting 05/11/2006. CT scan

shows incomplete fusion and radiography show angular change at the level of the fusion. Records document that the attending physician has diagnosed the claimant with a lumbar pseudarthrosis and is now requesting a L4-L5 posterior decompression and revision of the posterior lateral fusions.

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

Using ODG guidelines, further surgery would not be recommended or indicated. This patient would be unlikely to have a beneficial result of a fourth operation. The claimant suffers from failed back syndrome. An attempt has already been made to revise the fusions. Further surgery would not be medically necessary or appropriate based on the ODG guidelines and the records reviewed; therefore, 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)