



## Medwork Independent Review

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

04/28/2010

#### *MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 04/28/2010**

**IRO CASE #:**

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

Two level fusion at C5-6 & C6-7 with two day inpatient length of stay

**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 04/12/2010
2. Notice of assignment to URA 04/12/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 04/09/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 04/07/2010
6. letter 03/08/2010, 02/18/2010
7. Pre-auth 03/02/2010, 02/16/2010, medical note 02/11/2010, 01/19/2010, 01/15/2010, 12/14/2009, 11/19/2009, 11/18/2009, 11/11/2009, 11/04/2009, 11/02/2009, 10/19/2009, 10/13/2009, 10/09/2009, 09/25/2009, 09/17/2009, radiology 08/25/2009, medical note 08/19/2009
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

This patient had an injury on xx/xx/xx. The patient received non-operative treatment. Because of shoulder pain in association with neck pain, an MRI scan was carried out. The report



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indicates degenerative disk disease with marked disk bulging encroaching the anterior epidural space causing mild to moderate central canal stenosis of C5-6. The MRI scan result says, “no significant canal stenosis at C6-7.” A request has been made for a two level fusion at C5-6 and C6-7 with two day inpatient length of stay.

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

Based on the Official Disability Guidelines, MRI scan, and physical exam results the previous adverse determination is upheld for the requested two level fusion at C5-6 and C6-7 with two day inpatient length of stay. There is no indication in the medical records of any neurologic deficit. There is no neurologic deficits documented. There is no indication of any true cervical myelopathy or radiculopathy. The previous adverse determination is upheld based on the medical documentation reviewed and the Official Disability Guidelines.

### **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)