



Medwork Independent Review

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

10/27/2010

DATE OF REVIEW: 10/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient L4-L5, L5-S1 examination under anesthesia, laminectomy/decompression/discectomy;
L5-S1 arthrodesis with Cages, posterior instrumentation

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER
HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Texas State Licensed MD Board Certified Orthopedic 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 10/07/2010
2. Notice of assignment to URA 10/07/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 10/07/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/04/2010
6. Letter 10/12/2010, letter, 09/28/2010, 09/09/2010, medical 09/13/2010, letter 09/01/2010, medical
09/22/2010, 08/27/2010, 08/18/2010, 08/17/2010, 07/22/2010, 07/16/2010, 07/06/2010, 06/24/2010,
06/14/2010, 05/18/2010, 05/17/2010, 05/14/2010, 05/13/2010, 05/10/2010, 04/21/2010, 04/19/2010,
04/12/2010, 03/15/2010, 03/05/2010, 02/22/2010, 02/19/2010, 02/15/2010, 01/20/2010, 10/06/2009,
07/27/2009, 06/17/2009, 03/25/2009, 01/30/2009, 01/20/2009, 12/22/2008, 11/21/2008, 11/18/2008,
10/17/2010, 10/16/2008, daily treatment logs 04/26/2010 – 09/15/2009
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This individual was involved in an accident on xx/xx/xx. The patient has continued to have back
pain. The patient has been treated with an epidural steroid injection and with chiropractic
treatment. Review request is for inpatient L4-L5, L5-S1 examination under anesthesia,
laminectomy/decompression/discectomy; L5-S1 arthrodesis with Cages, posterior
instrumentation.

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



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Referring to the Official Disability Guidelines along with the medical records reviewed the patient does not fulfill the criteria for the requested procedure; therefore, the insurer's decision to deny is upheld. In review of the documentation, the MRI scan description of the L4-L5 and L5-S1 levels, at L4-L5, there appear to be mild disk desiccation with loss of vertical disk height. There was no significant central or foraminal stenosis. There was no description of any nerve root or thecal sac compression. There was no indication of any antero- or retrolisthesis. The description at L5-S1 indicates mild disk desiccation with normal sagittal plan alignment. There was some posterior displacement of the left S1 nerve root. There was some suggestion of arachnoiditis. There was no description of a spondylolisthesis or retrolisthesis. The lumbar spine x-rays, together with lateral flexion-extension radiographs, at L1-L2, there was a 3-mm retrolisthesis in extension and neutral alignment to flexion. At L2-L3, there was a 3-mm retrolisthesis in extension and neutral alignment in flexion. At L3-L4 there was a 3-mm retrolisthesis and neutral alignment in extension. There is a comment that "no segmental instability was identified at L4-L5 or at L5-S1." According to the physician's interpretation of x-rays of the lumbar spine, there was a change in angulation at L5-S1 between 6° and 25°. This was not confirmed by an outside source. There was no evidence of any spondylolisthesis. Per the ODG criteria the documentation reviewed is not supportive of the requested inpatient L4-L5, L5-S1 examination under anesthesia, laminectomy/decompression/discectomy; L5-S1 arthrodesis with Cages, posterior instrumentation.

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
- AHCP- 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



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FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)