



## Medwork Independent Review

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**DATE OF REVIEW: 10/27/2010 Amended: 10/28/2010**

**IRO CASE #:**

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

Inpatient transforaminal lumbar interbody fusion posterolateral fusion and instrumentation at L5-S1 with 3 day 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 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 10/12/2010
2. Notice of assignment to URA 10/12/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 10/12/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/06/2010
6. Review summary, letter 09/09/2010, 08/18/2010, Medicals 08/16/2010, 08/12/2010, 07/20/2010, 07/06/2010, 07/02/2010, 03/16/2010, 02/15/2010, 05/19/2009, 05/15/2009, 04/27/2009, 04/20/2009, 04/03/2009, 03/23/2009, 03/06/2009, 02/27/2009.
7. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

This individual was involved in an accident on xx/xx/xx. Claimant complains of low back pain. Patient had a transforaminal epidural steroid injection performed at the L4-5 interspace with no relief noted. Claimant states that symptoms are becoming worse regardless of conservative care. Review request is for inpatient transforaminal lumbar interbody fusion posterolateral fusion and instrumentation at L5-S1 with 3 day length of stay.

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

An MRI scan, dated March 6, 2009, revealed spondylolisthesis at L5 on S1. On April 20, 2009, EMGs were undertaken and these did not show any documented radiculopathy. The X-ray report, dated March 16, 2010, indicates that there may be anterior shift of L4 on L5. There is no



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description of a spondylolisthesis at L5 on S1. There is no description of instability, either angular or translational, at the L5-S1 level. Review of the medical documents fails to reveal x-rays at an outside facility documenting instability at L5-S1. Based on the criteria of the Official Disability Guidelines and the documentation presented for review, the requested procedure of inpatient transforaminal lumbar interbody fusion posterolateral fusion and instrumentation at L5-S1 with 3 day length of stay is upheld. Referring to the ODG, the medical records do not support recommended guidelines for the requested procedure; therefore, the insurer's decision to deny 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)