



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
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Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



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

**10/14/2010**

**DATE OF REVIEW: 10/14/2010**

**IRO CASE #:**

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

63075 Anterior cervical discectomy @ C4-5, C5-6, C6-7;  
63076 Addtl level;  
36081 Possible cervical corpectomy;  
63082 Possible addtl level;  
69990 microdissection technique;  
22554 cervical arthrodesis @ C4-5, C5-6, C6-7;  
22585 Addtl level;  
22851 Application of spinal biomechanical device;  
20938 Spinal bone autograft;  
22845 Insert spinal fixation device;  
22326 Reduction of subluxation-cervical;  
22328 Addtl level;  
99221 Inpatient hospitalization: 2 days

#### **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 to Medwork 09/27/2010
2. Notice of assignment to URA 09/27/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 09/24/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 09/23/2010



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6. Summary 9/27/2010, letter 9/20/2010, 9/9/2010, 1/25/2010, medicals 9/21/2010, 8/17/2010, 08/02/2010, 07/22/2010, 07/20/2010, 07/02/2010, 06/16/2010, 06/14/2010, 06/09/2010, 06/02/2010, 05/27/2010, 05/19/2010, 05/18/2010, 05/11/2010, 05/05/2010, 04/21/2010, 04/13/2010, 04/08/2010, 04/07/2010, 04/06/2010, 03/24/2010, 03/22/2010, 03/10/2010, 03/04/2010, 03/01/2010, 02/24/2010, 02/10/2010, 02/09/2010, 01/20/2010, 01/06/2010, 12/16/2009, 12/09/2009, 12/01/2009, 11/19/2009, 11/18/2009, 11/17/2009, 11/03/2009, 10/22/2009, 10/14/2009, 09/29/2009, 09/28/2009, 09/16/2009, 09/15/2009, 09/14/2009, 09/04/2009, 09/03/2009, 08/31/2009, 08/26/2009, 08/17/2009, 07/30/2009, 07/29/2009, 07/20/2009, 07/16/2009, 07/15/2009, 06/30/2009, 06/24/2009, 06/03/2009, 05/29/2009, 05/28/2009, 05/26/2009, 05/21/2009, 05/12/2009, 05/08/2009, 03/29/2009, 03/22/2009, 03/21/2009, 03/21/2009, TDI forms 3/2009 – 8/2010
7. ODG guidelines were not provided by the URA

### **PATIENT CLINICAL HISTORY:**

This claimant was involved in an accident on xx/xx/xx. Records indicate that right reflexes to be 1/4, left reflexes to be 2/4, and grip strength on the right side to be 4+/5. It is documented that neurologic exams are normal. EMG studies were interpreted as normal. Review request is for a 63075 anterior cervical discectomy @ C4-5, C5-6, C6-7; 63076 addtl level; 36081 possible cervical corpectomy; 63082 possible addtl level; 69990 microdissection technique; 22554 cervical arthrodesis @ C4-5, C5-6, C6-7; 22585 addtl level; 22851 application of spinal biomechanical device; 20938 spinal bone autograft; 22845 insert spinal fixation device; 22326 reduction of subluxation-cervical; 22328 addtl level; and 99221 inpatient hospitalization: 2 days.

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

The previous adverse determination is upheld based on the medical documentation reviewed and the Official Disability Guidelines. There is no neurologic deficits documented. There is no indication in the medical records of any neurologic deficit. The MRI scan findings do not suggest any major spinal cord compression. The insurer's decision to deny the requested multilevel discectomy, decompression, and fusion 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 KNOWLEDGEBASE
- 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



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- 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)**