



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



### *MEDWORK INDEPENDENT REVIEW WC DECISION*

**DATE OF REVIEW: 11/08/2011**

**IRO CASE #:**

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

Is the posterior lumbar decompression and fusion at L2-3/L3-4 considered medically necessary for this patient?

**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. Assignment to 10/27/2011
2. Notice of assignment to URA 10/26/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 10/26/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 08/30/2011
6. Letter from Attorney 10/28/2011, Medicals 10/18/2011, 09/21/2011, 09/13/2011, 09/02/2011, 08/31/2011, 08/19/2011, 08/13/2011, 08/12/2011, 08/09/2011, 08/05/2011, 08/04/2011, 07/29/2011, 07/28/2011, 07/26/2011, 07/22/2011, 07/21/2011, 07/19/2011, 07/15/2011, 07/13/2011, 07/11/2011, 06/28/2011, 06/27/2011, 06/24/2011, 06/22/2011, 06/21/2011, 06/14/2011, 06/09/2011, 06/08/2011, 06/03/2011, 05/26/2011, 05/20/2011, 05/18/2011, 05/17/2011, 05/16/2011, 05/13/2011, 05/12/2011, 05/11/2011, 05/09/2011, 05/04/2011, 05/03/2011, 04/29/2011, 04/13/2011, 04/01/2011, 03/30/2011, 03/28/2011, 03/04/2011, 03/03/2011, 02/28/2011, 02/10/2011, 02/07/2011, 02/02/2011, 12/22/2010, 12/16/2010, 11/16/2010, 11/10/2010, 11/09/2010, 11/08/2010, 10/19/2011, 10/01/2010, 09/23/2010, 08/24/2010, 08/17/2010, 08/10/2010, 08/02/2010, 06/28/2010, 06/24/2010, 06/10/2010, 05/11/2010, 04/30/2010, 03/31/2010, 03/25/2010, 03/04/2010, 02/04/2010, 01/21/2010, 12/18/2009, 11/05/2009, additional information
7. ODG guidelines were not provided by the URA



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



### **PATIENT CLINICAL HISTORY:**

The patient was injured on xx/xx/xx. The patient has had surgery. This has been at the L4-L5 level.

The patient had an MRI scan carried out on May 26, 2011. There are postoperative changes with a prosthetic disk at the L4-L5 level. At L5-S1 there has been previous surgery with posterior fixation and prosthetic disk with laminectomy.

The description of the L2-L3 level is that there is disk desiccation with decrease in disk space height. There is a broad-based disk bulge/protrusion producing narrowing of the lateral recesses. There is hypertrophy of the facet and ligamentum flavum.

At L3-L4 there is an anterolisthesis. There is a 4-mm disk bulge/protrusion.

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

This patient has not demonstrated any evidence of instability. The patient has had a mental health exam on July 29, 2011. This indicated some suggestion of symptom magnification and depression.

Using Official Disability Guidelines, a posterior lumbar decompression and fusion at L2-L3 and L3-L4 is not a reasonable treatment choice; therefore, the previous adverse determination should be upheld.



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



### 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)