



Medwork Independent Review

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

Date: October 17, 2011

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 10/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the posterior lumbar interbody fusion L5-S1, and inpatient length of stay x3 days, 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 [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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 09/27/2011
2. Notice of assignment to URA 09/27/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 09/27/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 09/26/2011
6. Letter from Claims 09/27/2011, Letter from patient 09/26/2011, Letter from Orthopedic 09/08/2011, Letter from patient 09/01/2011, Ins Verification 08/29/2011, Letter from Orthopedic 08/18/2011, Letter from Physician 08/11/2011, Letter from Orthopedic 07/14/2011, Letter from Consultant 05/31/2011, Letter from Orthopedic 05/19/2011, Letter from Claims 05/12/2011, Letter from Orthopedic 05/05/2011, 04/28/2011, 02/16/2011, 01/17/2011, 01/06/2011, MRI Report 12/13/2010
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY



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This patient's original injury was in xx/xxxx. He had a prior history of lumbar surgery. Subsequent to this accident, he has been treated with therapy and epidural steroid injections.

At the present time, his MRI scan shows a disk herniation at L5-S1 with some mild loss of disk space height. There is disk desiccation noted at L4-L5 and at L5-S1.

There is no indication that flexion-extension films documented any instability pattern. Indeed, flexion-extension films carried out in September specifically did not demonstrate criteria for instability.

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

Using Official Disability Guidelines, this patient does not fulfill criteria warranting fusion.

After careful review of this information, the opinions that were previously expressed remain unchanged. The previous adverse determination should be upheld. There is insufficient documentation as to the necessity of posterior lumbar interbody fusion at L5-S1.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG GUIDELINES MUST BE USED IN DECISION = PER TX RULE

- 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
- 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)