



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



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

DATE OF REVIEW:

7/31/2012

IRO

CASE

#:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy at L4-L5
and L5-S1

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

Texas State Licensed MD Board Certified Neurology
physician

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

(A

agree) Overturned

(Di

sagree)

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.

PATIENT CLINICAL HISTORY:

The patient is a male having been involved in a motor vehicle accident on xx/xx/xx. The patient has had reported persistent low back pain with radiation into the lower extremities with decreased sensation in the L5 distribution. The patient has positive straight leg raising on the right and reported herniated disks at L4-L5 and L5-S1. It is reported by the treating physician that the non-operative treatment has failed. The review of the records being performed at the time revealed the aforementioned findings per the treating provider's records, the MRI, the lumbar spine from X-ray revealed as of 03/14/2012 that L3- L4 are bulging disks and L4-L5 left foraminal protrusion and mild stenosis with a "patent right foremen." There was a left paracentral disk protrusion displacing the left L5 root with the central canal mildly than moderate facet osteoarthritis. At L5-S1 the bulging disk with biforaminal protrusion with moderate



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



foraminal stenosis and moderate facet osteoarthritis.

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

The records reveal that there appears to be a discrepancy between the overall subjective and objective findings and the MRI imaging report. The MRI imaging report does not support significant nerve root impingement on the right side, the side that has been considered for decompression of both L4-L5 and L5-S1. In addition, electrodiagnostics have not been submitted to corroborate any such right sided radiculopathy. In addition, there appears to be a discrepancy in treating provider's impression of the MRI findings and the radiologist with the treating provider concerning there to be herniated disks with nerve root impingement on the right side and the radiologist not indicating the same. There has not been evidence provided of actual physical therapy records and specific medications in response to medications therapy and/or epidural steroid injection to assess the detailed reported trial and failure, comprehensive and recent non-operative treatment; therefore, the applicable ODG Guidelines have not been met with regard to the requested consideration for decompression laminectomy discectomy at L4-L5 and L5-S1 and the insurer's denial 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 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)