Medwork Independent Review
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

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

March 2, 2012

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 3/1/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Inpatient lumbar spine surgery, L5-S1 revision laminectomy, discectomy, and fusion with instrumentation and implantable bone growth stimulator.

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 2/21/2012
2. Notice of assignment to URA 2/17/2012
3. Confirmation of Receipt of a Request for a Review by an IRO 2/17/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 2/17/2012
6. Information of review determination 2/23/2012, 2/15/2012, notice of dispute 2/7/2012, concurrent determination 2/7/2012, pre-authorization request undated, medicals 1/31/2012, 1/9/2012, review determination 12/19/2011, medicals 12/5/2011, 11/30/2011, 11/29/2011, diagnostic imaging 10/28/2011, office visit report 6/28/2011, surgical consultation report 3/22/2011, medicals 11/08/2010, 8/18/2010, 6/14/2010, 2/10/2010, interim consultation report 12/04/2009, medicals 9/01/2007, 6/19/2007, evaluation report 6/19/2007, medical record review 4/06/2006, pre-medicals 1/20/2005, authorization report 5/22/2003, medicals 5/25/2002.
7. ODG guidelines were not provided by the URA

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PATIENT CLINICAL HISTORY:

The patient is a male, that is a 300-pound-plus diabetic with a history of smoking. The patient has been documented as being status post prior discectomy at the L5-S1 level. The patient has been documented to have a chronic, recurrent, residual disk fragment at the L5-S1 level. The patient's physician has indicated that his patient has an indication for decompression and fusion at L5-S1. Letters from the physician discuss functional unit collapse at L5-S1. The physician's review of flexion-extension films, document such a functional unit collapse. A radiologist's review of flexion-extension films, do not reveal evidence of any segmental instability at the proposed level of surgical intervention. The documents reveal that the patient is felt to be a suboptimal candidate for surgical intervention form a physical standpoint, i.e., having comorbidities in addition to not having evidence of segmental instability as per the radiologist.

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

The patient has not been documented to have significant radiological evidence of either instability or functional unit collapse as per the radiologist's view. He does not appear to be an optimal surgical candidate due to his body habitus and a history of ongoing diabetes and smoking. The known association with an increased risk of pseudoarthrosis and smoking has been well documented in the medical literature overall and clearly is a relative contraindication for Official Disability Guidelines. Official Disability Guidelines would typically only support both decompression and fusion in a case of documented segmental instability and collapse that has not responded to reasonable non-operative treatment. In this case, with a suboptimal candidate from a physical standpoint and with the lack of Official Disability Guidelines-associated indications for the proposed fusion procedure based on the clinical records reviewed including, but not limited to, the radiologist's report, it is documented that at this time there is a lack of positive correlation between the documentation and the Official Disability Guidelines' criteria; therefore, 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**

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- ☐ **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)**