Medwork Independent Review
5840 Arndt Rd., Ste #2
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
WORKERS' COMPENSATION - WC

DATE OF REVIEW: 8/8/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Instrumentation explantation, decompression, and instrumentation of nerve root canal at L4-L5 and L5-S1 with 1-3 inpatient days.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Orthopedic 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. Dept of Insurance Assignment to Medwork 7/19/2013,
2. Notice of assignment to URA 7/11/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 7/19/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 7/18/2013
   Letter to physician 6/20/2013, 6/19/2013, medical information 6/18/2013, medical notes 6/17/2013, appeal reconsideration request for pre-authorization 6/13/2013, letter 6/11/2013, medical notes 6/6/2013, health insurance claim form 6/5/2013, 5/31/2013, medical notes from MRI 5/23/2013, medical notes 5/10/2013, medical notes 5/8/2013, Letter to physician 5/8/2013, request for pre-authorization 5/3/2013, treatment progress notes 4/25/2013, statement of pharmacy services 3/21/2013, medical notes 3/20/2013, treatment progress report 2/22/2013, initial diagnostic screening 9/21/2012, medical notes 9/23/2011, lower EMG and nerve conduction study 12/10/2009.

PATIENT CLINICAL HISTORY:

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The patient has been well documented to be status post multiple surgical interventions for an injury sustained in xx/xxxx.

The patient has been noted in the past to have decompression and fusions, including at least one episode of treatment of pseudoarthrosis. Most recently, the patient underwent an L4-L5 and L5-S1 fusion. The patient was noted, on a prior MRI from September 23, 2011, to have enhancing scar and disk abutting the L5 nerve roots at the L5-S1 neural foramen, the scar encasing the S1 nerve roots at the lateral recess. The patient was further noted, as of 2013, to have recurrent back pain, worse with activities, as noted on March 20, 2013. There was pain emanating from the low back into the lower extremities with paresthesias into the lower extremities.

A lumbar spine MRI from May 23, 2013, revealed a prior anterior fusion from L3 to S1 with posterior fusion, including instrumentation, from L3 to L5. As noted, there had been ongoing abutment of the L5 nerve roots in the neural foramen and a posterior annular disk bulge at L2-L3.

Hardware block was performed on May 30, 2013, at L4-L5 and L5-S1. There reportedly had been a 50% reduction in the low back pain, as noted on June 6, 2013. This was felt attributable to the hardware block that lasted approximately a 2-week period. The patient was noted to have paraspinal tenderness, tenderness reportedly over the pedicle screw heads and in the sciatic notch, similar to prior evaluations. The patient was noted to have pain on range of motion of the lumbar spine, including at the uppermost portion of the hardware around L2. The decreased sensation was noted at the medial aspect of the left foot and the left great toe and the posterolateral thigh. There was noted to be hip flexion of 4/5 bilaterally with regard to motor strength. Otherwise, strength was 5/5 in the lower extremities. Achilles reflexes were noted to be absent on the left and 1/4 on the right. There were trace patellar reflexes with distraction only.

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

The documentation provided supports at most that there may well be an indication for removal of the spinal instrumentation. However, there does not appear to be documentation of segmental instability nor any evidence of pseudoarthrosis or nonunion associated with prior fusion attempts. The documentation most recently from the patient appears to reflect primarily, if not exclusively, an indication for removal of hardware as opposed to additional hardware insertion. In any event, the patient, although appearing to have an indication for hardware removal, does not appear at this time without an intervening period of treatment and/or diagnostic workup post hardware removal to have an indication for reinsertion of additional hardware. The requested length of stay, therefore, is not medically necessary or reasonable at this time.

The denial of these services is upheld.

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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)**