



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

July 17, 2013

DATE OF REVIEW: 7/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy and discectomy 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 Neurosurgeon.

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 6/27/2013
2. Notice of assignment to URA 6/25/2013
3. Confirmation of Receipt of a Request for a Review by an IRO 6/27/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/26/2013

Additional physicians or health care providers form, letter to physician from insurance plan 6/20/2013, preauthorization request 5/29/2013, progress notes 5/23/2013, letter to member from insurance plan 5/21/2013, operative report 5/16/2013, progress notes 5/14/2013, medical notes 5/6/2013, MRI report 4/26/2013, progress notes 4/12/2013, 3/21/2013, 3/13/2013, 3/5/2013, 3/1/2013, medical notes 2/7/2013, progress notes 2/4/2013, 1/24/2013, evaluation rehabilitation treatment notes 1/24/2012, initial interview 12/20/2012, medical notes 10/23/2012, progress notes 9/25/2012, nerve conduction study/electromyography study 8/31/2012, test date 8/31/2012, MRI lumbar spine wo/contrast notes 3/14/2012.

PATIENT CLINICAL HISTORY:



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This is a male with a date of injury of xx/xx/xx. He complains of low back pain radiating into the lower extremity. He was treated with medications, chiropractic visits, work hardening, and physical therapy.

On October 23, 2012, his examination showed reduction of the knee jerk on the right and reduction of Achilles jerk on the right. His examination on May 23, 2013, showed a positive straight leg raising, mainly on the right. He also had reduction of pinprick sensation in the L5-S1 distribution on the right. There was also a reduced Achilles jerk on the right.

An EMG/nerve conduction study of the lower extremities on August 31, 2012, showed mild bilateral L4 radiculopathy.

An MRI of the lumbar spine, April 26, 2013, with or without contrast, showed at L4-L5 a broad-based 0.3-cm disk herniation with right facet arthropathy flattening the thecal sac and contributing to mild bilateral neural foraminal narrowing. At L5-S1, there is a broad-based 0.3-cm disk herniation with loss of disk height and mild facet hypertrophy approaching the thecal sac and contributing to moderate left and mild right neural foraminal narrowing. The provider is requesting a lumbar laminectomy and discectomy at L4-L5 and L5-S1 with CPT codes 63047 and 63048, with a 1-day length of stay.

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

The recommendation is for approval of this surgery based on *Official Disability Guidelines'* criteria for discectomy.

The patient has objective evidence of both L5 and S1 radiculopathies. There is EMG evidence of bilateral L5 radiculopathies. In addition, the patient has evidence of an S1 radiculopathy, as evidenced by an absent Achilles reflex and sensory changes in the L5-S1 distribution. There is neural imaging to correlate with this, as evidenced by foraminal narrowing at the L4-L5 and L5-S1 disk spaces. The patient has failed conservative treatment since the injury, consisting of medications, chiropractic therapy, and work hardening, as well as physical therapy.

This procedure was denied on prior review due to the fact that the patient had not undergone epidural steroid injections. However, upon review of *Official Disability Guidelines'* criteria for discectomy/laminectomy, an epidural steroid injection is considered part of conservative treatment. However, it is not mandated as absolutely necessary prior to undergoing surgery under "Section 3, Conservative Therapies: b. Drug therapy requiring at least one of the following: NSAID therapy, other analgesics, muscle relaxants, or epidural steroid injections."

Therefore, this procedure should not be denied simply because the patient has not undergone an epidural steroid injection. He clearly has undergone medications and multiple other conservative



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measures. Moreover, he has objective evidence of radiculopathy that correlates with his neural imaging.

Therefore, this procedure is medically necessary and consistent with *Official Disability Guidelines'* criteria for a lumbar decompression at the aforementioned levels at L4-L5 and L5-S1.

The denial of the services is overturned.

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)