



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC*

May 1, 2013

**DATE OF REVIEW:** 4/29/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Patient removal of hardware and augmentation of fusion of thoracic.

**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**

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. Texas Dept of Insurance Assignment 4/12/2013
2. Notice of assignment to URA 4/10/2013
3. Confirmation of Receipt of a Request for a Review by an IRO 4/12/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 4/11/2013
6. Notes from treating physician 4/12/2013, 4/9/2013, notification of reconsideration determination 4/1/2013, notes from treating physician 3/8/2013, 3/5/2013, notification of adverse determination 2/15/2013, notes from treating physician 2/9/2013, 1/29/2013, CT scan notes from imaging center 1/28/2013, notes from treating physician 1/26/2013, 1/8/2013, 7/26/2012, 7/10/2012, 5/29/2012, 12/22/2011, 11/17/2011, 11/1/2011, 9/27/2011, 8/18/2011, 8/4/2011.

**PATIENT CLINICAL HISTORY:**

The patient has been well documented to be a female who was injured on xx/xx/xx attributable to a fall. The patient has a history of being treated for compression fractures with vertebroplasty. The patient also has been treated for lumbar stenosis and back pain. The patient most recently



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has had pain, reported swelling, and also tenderness over the incision from prior surgery. The patient has been noted to have undergone a CT scan dated 01/28/2013. The report of the thoracic spine revealed the residual TA slight compression fracture and post vertebroplasty procedure with retained hardware overall. Within the retained hardware there was noted to be evidence of radiolucency at the T9 pedicle screw with a sign of a loose screw. No recurrent herniation or stenosis was noted.

The most recent clinical notes and the treating provider reports ongoing and increased back pain and that the patient was neurologically intact. The patient has been noted to have the reported tenderness and the loose screw on the imaging studies, and has been felt to have an indication for removal of hardware and fusion augmentation T7-T9 on the right side for the treating provider. Denial letters have discussed the lack of complete demonstration of other pain generators in particular. In addition, the lack of a diagnostic hardware injection has also been noted.

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

The patient clearly has persistent and increased pain and objective findings of peri-incisional tenderness and imaging findings of a loose screw. However, the documentation has not definitively evidenced plausible assessment and elimination of other potential sources of pain generation. In addition, the patient has not undergone evidence of a diagnostic hardware injection, which is one of the primary clinical guideline criteria for assessment as to whether or not the loose hardware is a significant source of pain generation. At this time, without full apparent assessment of the pain generator as being from the reported loose hardware and without full confirmation that the patient has symptomatic loose hardware overall could be based on a past diagnostic hardware injection. The requested aggregate procedure is not considered medically reasonable or necessary at this time, exclusively based upon applicable clinical guidelines. ODG guidelines with regard to hardware removal of the spine and also lumbar fusion are applicable in this case.

The denial of the 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)