



## 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](http://www.medwork.org)



### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC*

**DATE OF REVIEW:** 5/27/2014

**IRO CASE #:**

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

Outpatient lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1.

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

Texas State Licensed MD Board Neurological 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**

**PATIENT CLINICAL HISTORY:**

This is a male with a date of injury xx/xx/xx, when he fell to the floor. He complains of low back pain, with radiation into the bilateral lower extremities, left greater than right, posteriorly into the buttocks and terminating in the calf. He has been treated with physical therapy, medications, and 1 epidural steroid injection (December 21, 2013). His examination February 10, 2014 shows 4 out of 5 strength of the left gastrocnemius; otherwise, normal strength throughout. He has difficulty with toe walking secondary to pain and weakness and heel walking secondary to pain. There is positive straight leg raising on the left. Sensory examination reveals a hypoesthetic region of an S1 distribution on the left. An MRI of the lumbar spine October 21, 2013 shows borderline calcinosis at L3-L4 due to epidural lipomatosis and facet disease. At L5-S1 there is a 7 mm left paracentral protrusion with thecal sac and nerve root impingement of S1, moderate left neural foraminal narrowing. There is canal stenosis from the moderate facet arthropathy and epidural lipomatosis. The provider is requesting a lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L5-S1.



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

The lumbar laminectomy, diskectomy, foraminotomy, and partial facetectomy at L5-S1 is appropriate and medically necessary. According to the ODG low back chapter section on diskectomy, there should be symptoms and findings confirming the presence of radiculopathy. In this case, there is weakness at the gastrocnemius on the left and positive straight leg raising on the left, and bilateral leg symptoms, left greater than right. Imaging studies should also show concordance between radicular findings on radiologic evaluation and physical examination findings according to the ODG. In this case there is documented herniated disk to the left with nerve root compromise at L5-S1. Conservative treatment should also have been exhausted. This claimant has undergone a home exercise program, physical therapy, medications, as well as an epidural steroid injection. Therefore, the claimant's condition does meet ODG criteria for diskectomy, and the surgery is therefore appropriate and medically necessary.

### **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)**