Medwork Independent Review
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Network (WCN)

DATE OF REVIEW: **03/30/2011**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Laminectomy, discectomy at L3-4 L5-S1; arthrodesis w cages, posterior instrumentation at L3-4 & 2 day stay (63030, 63035, 69990, 22612, 22899, 22840, 22851, 22325, 22558, & 20938)

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. Assignment 03/16/2011
2. Notice of assignment to URA 03/16/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 03/15/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 03/09/2011
6. Medical Review 03/14/2011, Insurance Letter 03/04/2011, Medical Review 03/04/2011, Insurance Letter 02/24/2011, Preauthorization 02/23/2011, Medicals 08/19/2010, 02/15/2010, 12/14/2010, 11/16/2010, 11/03/2010, 09/17/2010, 06/15/201006/15/2010, 06/02/2010, 05/30/2010, 05/28/2010, 03/11/2010, 03/09/2010, 03/08/2010, 01/19/2010, 12/02/2009, 11/25/2009, 11/11/2009, 10/21/2009, 10/02/2009, 07/27/2009, 07/15/2009 TDI Form, HCFA.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:
This patient was originally injured on XX/XX/XXXX. The patient underwent MRI scanning. There was no evidence of any instability at any level. Notes indicate that there are coexisting factors, including morbid obesity and smoking. Flexion-extension films were taken and noted that unable to visualize the L5-S1 level because of obesity. It is noted that at L4-L5 there was an extension at 11 degrees. There wasn't any flexion angle noted. Review request is for

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laminectomy, discectomy at L3-4 L5-S1; arthrodesis w cages, posterior instrumentation at L3-4 & 2 day stay (63030, 63035, 69990, 22612, 22899, 22840, 22851, 22325, 22558, & 20938).

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

According to the Official Disability Guidelines recommendations along with the review records, this patient does not fulfill the criteria for the requested laminectomy, discectomy at L3-4 L5-S1; arthrodesis w cages, posterior instrumentation at L3-4 & 2 day stay (63030, 63035, 69990, 22612, 22899, 22840, 22851, 22325, 22558, & 20938). There was no evidence of instability using Official Disability Guidelines' criteria. X-rays were taken again and it was noted that there was decreased disc space height at L3-L4. This in and of itself is not an indication of instability. There was no indication of any translation or angular change at the L3-L4 level. The insurer's decision to deny the requested laminectomy, discectomy at L3-4 L5-S1; arthrodesis w cages, posterior instrumentation at L3-4 & 2 day stay (63030, 63035, 69990, 22612, 22899, 22840, 22851, 22325, 22558, & 20938) 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**
- ☐ **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)**