

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 06/29/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L3 paralateral discectomy, Metr'X-X tub system, and two day length of stay

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

Board Certified in Orthopedic Surgery

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

An evaluation and EMG/NCV study with M.D. dated 01/23/04
A lumbar discogram interpreted by M.D. dated 02/02/04
Operative reports from M.D. dated 04/05/04 and 04/06/05
Evaluations with Dr. dated 09/09/04, 10/08/04, 10/19/04, 12/14/04, 04/21/05, 05/19/05, 04/13/06, 04/03/07, and 04/17/07
Evaluations with P.A.-C. for Dr. dated 03/03/05, 04/01/05, 10/27/05, 11/29/05, 12/06/05, and 05/08/07
An NCV study interpreted by M.D. dated 07/28/05
Preauthorization requests from Dr. dated 04/17/07, 05/10/07, and 05/17/07
An MRI and x-rays of the lumbar spine interpreted by , M.D. dated 05/04/07
A letter of non-certification from , M.D. dated 05/15/07
A request for reconsideration letter from Dr. dated 05/15/07
A letter of non-certification from M.D. dated 05/22/07
A letter from Dr. dated 05/24/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 01/23/04, Dr. prescribed Skelaxin and Bextra and performed an EMG/NCV study, which was normal. A lumbar discogram interpreted by Dr. on 02/02/04 revealed concordant pain at L4-L5 and L5-S1. On 04/05/04, Dr. performed surgery at L4 through S1. On 09/09/04 and 12/14/04, Dr. refilled Darvocet. On 04/06/05, Dr. removed spinal instrumentation. An NCV study interpreted by Dr. on 07/28/05 revealed likely residual findings of previous radiculopathy at L5 and S1 on the left. On 10/27/05, Mr. requested an MRI of the brachial plexus. On 04/13/06, Dr. prescribed Darvocet and Zanaflex. On 04/03/07, Dr. prescribed a Medrol Dosepak, Darvocet, and Zanaflex. On 04/17/07, Dr. requested a lumbar MRI. An MRI of the lumbar spine interpreted by Dr. on 05/04/07 revealed postoperative changes at L4-L5 and L5-S1 and a disc herniation at L3-L4 that impinged on the right L3 nerve root. On 05/08/07, Mr. requested another lumbar surgery. On 05/15/07, Dr. wrote a letter of non-authorization for surgery. On 05/22/07, Dr. also wrote a letter of non-authorization for the surgery. On 05/24/07, Dr. wrote a letter of necessity for the surgery.

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

This patient underwent a two level interbody fusion by Dr. allegedly as a result of the occupational injury. This was performed on 04/05/04. There is a 3% incidence per year of degenerative change above a well healed fusion. This is a direct result of the fusion. There is no evidence of any intervening injury. The patient had symptoms consistent with compression of the L3 nerve root. Therefore, the requested right L3 paralateral discectomy, Metr'X-X tub system, and two day length of stay is reasonable, necessary, and related to the occupational injury.

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 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)**