

RYCO MedReview

DATE OF REVIEW: 03/30/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient anterior interbody lumbar fusion at L4-L5 with three day length of stay

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

Board Certified

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 MRI of the lumbar spine interpreted by, D.O. dated 09/21/05
A Designated Doctor Evaluation with, D.O. dated 03/22/06
An EMG/NCV study of the lower extremity interpreted by, M.D. dated 04/05/06
A lumbar myelogram interpreted by, D.O. dated 06/30/06
A post myelogram CT scan interpreted by, D.O. dated 06/30/06
A procedure note from, M.D. dated 09/25/06
Evaluations with Dr. dated 10/13/06, 12/08/06, and 01/19/07
An MRI of the lumbar spine interpreted by, M.D. dated 11/27/06

A lumbar discogram and post discogram CT scan interpreted, M.D. dated 01/12/07

A psychological evaluation with, M.A., L.P.C. dated 01/23/07

A preauthorization request from Dr. dated 01/28/07

A letter of non-certification from, D.O. at dated 02/05/07

A letter of adverse determination from, L.P.N. at dated 02/09/07

A letter of non-certification from, M.D. at dated 02/13/07

A letter of non-authorization from, R.N. at dated 03/13/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine interpreted by Dr. on xx/xx/xx revealed diffuse disc bulges and two questionable cysts at S2. On 03/22/06, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. An EMG/NCV study interpreted by Dr. on 04/05/06 was unremarkable. A lumbar myelogram interpreted by Dr. on 06/30/06 revealed slight degenerative disc narrowing at L4-L5 and L5-S1. A post discogram CT scan interpreted by Dr. on 06/30/06 revealed diffuse disc bulging at L2 through S1 with associated narrowing and stenosis. On 09/25/06, Dr. performed an epidural steroid injection (ESI). On 10/13/06, Dr. ordered a repeat lumbar MRI. A lumbar MRI interpreted by Dr. Dr. on 11/27/06 revealed mild degenerative changes throughout the spine. A lumbar discogram and CT scan interpreted by Dr. on 01/12/07 revealed concordant pain at L4-L5 and L5-S1 and tears at L3-L4 and L4-L5. On 01/19/07, Dr. requested surgery. On 01/23/07, Ms. requested a work hardening program. On 02/05/07, Dr. wrote a letter of non-authorization for surgery. On 02/09/07, Ms. wrote a letter of non-authorization for a TLSO brace. On 02/13/07, Dr. also wrote a letter of non-authorization for surgery. On 03/13/07, Ms. wrote a letter upholding the denial for surgery.

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

The patient had a lifting injury. There are abnormal degenerative changes at multiple levels. Facing the surgical procedure alone on discography is neither reasonable nor necessary. The medical evidence is conflicting with regard to the exact location of the patient's pain. A more appropriate intervention for this individual would be physical therapy and work conditioning.

Criteria utilized: [ACOEM Guidelines](#) and [North American Spine Society Phase III Guidelines](#)

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)**

North American Spine Society Phase III Guidelines