



PROFESSIONAL ASSOCIATES

DATE OF REVIEW: 05/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior decompression and discectomy at L5-S1 with a one to two day length of stay and a Cybertech LSO brace

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

MRIs of the lumbar spine interpreted by, M.D. dated xx/xx/xx and 09/05/06
Evaluations with, M.D. dated 10/20/04, 11/17/04, 12/29/04, 03/30/05, 04/25/05,
06/14/06, 09/21/06, 12/18/06, and 01/18/07

Physical therapy with an unknown therapist (signature was illegible) dated 09/26/06

A physical therapy evaluation with the unknown therapist dated 09/27/06

A Designated Doctor Evaluation with, M.D. dated 10/10/06

A work/school release note from Dr. dated 11/02/06

A rebuttal letter from, D.C. dated 02/16/07

DWC-73 forms from Dr. dated 03/02/07, 03/21/07, 03/26/07, and 04/09/07

An evaluation with, M.D. dated 03/07/07

A request for modification letter from Dr. dated 03/12/07

A preauthorization request from Dr. dated 03/20/07

Letters of non-certification from, R.N. at SRS dated 03/28/07 and 04/06/07

Evaluations with Dr. dated 04/20/07 and 04/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine interpreted by Dr. on xx/xx/xx revealed discogenic and spondylitic changes from L3 to S1. On 10/20/04, Dr. requested physical therapy, possible epidural steroid injections (ESIs), and a possible lumbar myelogram CT scan. On 12/29/04, Dr. requested ESIs. On 04/25/05, Dr. recommended spinal rehabilitation. On 06/14/06, Dr. ordered an MRI of the lumbar spine and a lumbar ESI. An MRI of the lumbar spine interpreted by Dr. on 09/05/06 revealed a mild disc bulge at L5-S1. On 09/21/06, Dr. requested physical therapy. Physical therapy was performed with the unknown therapist on 09/26/06. On 10/10/06, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 12/18/06 and 01/18/07, Dr. requested further physical therapy. On 02/16/07 and 03/12/07, Dr. requested a surgical consultation. On 03/28/07 and 04/06/07, Ms. wrote letters of non-certification for surgery.

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

The patient did have a disc herniation at the time of the original MRI. However, subsequent MRIs showed that the disc herniation reabsorbed, leaving the patient with degenerative changes at L5-S1. His symptoms are axial, that is back pain rather than radicular pain. A landmark article by, M.D., in The Journal of the Spine, indicates the clinical results from a decompression are linearly related to the size of the disc herniation. That is small disc bulges such as this individual exhibits are not well treated by surgical intervention. In my opinion, the requested posterior disc decompression and discectomy at L5-S1 is neither reasonable nor necessary. In addition, the length of stay of "one to two days", as well as would be unreasonable even if the surgery was performed.

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 AND KNOWLEDGE BASE
- 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)

A landmark article by Eugene Caragee, M.D., in The Journal of the Spine