

RYCO MedReview

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/09/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Interbody fusion and discectomy at L5-S1, interbody fixation at L5-S1, posterior decompression at L5-S1, transverse process fusion at L5-S1, and a posterior internal fixation at L5-S1 with a one 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

Evaluations with P.A. dated 03/16/05 and 03/28/05
Medication prescriptions from Ms dated 03/16/05

A work status note from Ms. dated 03/28/05
A letter from., dated 06/03/05
Prescriptions from Ms. dated 08/10/05
Evaluations with M.D. dated 11/02/05, 01/11/06, 02/07/06, 06/19/06, 07/13/06, 08/28/06, 09/26/06, 10/10/06, 10/26/06, 11/16/06, 01/15/07, 02/15/07, and 03/14/07
Medication prescriptions from Dr. dated 11/02/05
An MRI of the lumbar spine interpreted by Dr. (no credentials were listed) dated 01/31/06
Required Medical Evaluations (RMEs) with M.D. dated 02/15/06 and 05/18/06
A letter from Dr. dated 03/07/06
An EMG/NCV study interpreted by M.D. dated 03/31/06
Physical therapy evaluations with M.P.T. dated 06/26/06 and 08/21/06
Designated Doctor Evaluations with D.O. dated 06/28/06, 11/14/06 and 02/20/07
Physical therapy with P.T.A. dated 06/29/06, 06/30/06, 07/03/06, 07/05/06, 07/07/06, 07/10/06, 07/12/06, 07/19/06, 07/21/06, 07/24/06, 07/26/06, and 09/08/06
A discharge report dated 07/26/06
Physical therapy dated 08/25/06, 08/30/06, 09/01/06, 09/06/06, 09/27/06, and 09/29/06
A hospital note from Dr. dated 09/13/06
A note from Dr. dated 10/10/06
X-rays of the lumbar spine interpreted by M.D. dated 11/28/06
Evaluations with M.D. dated 11/29/06 and 03/14/07
A letter of certification from Utilization Review Nurse dated 12/13/06
A referral form from Dr. dated 01/03/07
Evaluations with M.D. dated 02/05/07 and 02/26/07
A Functional Capacity Evaluation (FCE) with an unknown provider (no name or signature was available) dated 02/14/07
A preauthorization request from Dr. dated 03/20/07
Letters of non-certification dated 03/23/07 and 03/26/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 03/16/05, Ms. prescribed Celebrex, Lortab, and Skelaxin. On 02/07/06, Dr. requested a surgical consultation. An MRI of the lumbar spine interpreted by Dr. Sheward on 01/31/06 revealed degenerative changes at L3 through S1. On 02/15/06, Dr. felt the claimant was not at Maximum Medical Improvement (MMI) and requested an EMG/NCV study and physical therapy. An EMG/NCV study interpreted by Dr. on 03/31/06 revealed mild left-sided L5 radiculopathy. On 06/28/06, Dr. felt the claimant was not at MMI and would require further treatment. Physical therapy was performed with Ms. from 06/29/06 through 09/08/06 for a total of 12 sessions. Physical therapy was performed with Mr. from 08/25/06 through 09/29/06 for a total of six sessions. On 11/14/06, Dr. felt the claimant was still not at MMI and she requested a neurosurgical evaluation. X-rays of the lumbar spine interpreted by Dr. on 11/28/06 revealed degenerative

disease. On 11/29/06, Dr. requested an epidural steroid injection (ESI). On 02/05/07 and 02/26/07, Dr. performed ESIs and a median branch blocks. An FCE with an unknown provider on 02/14/07 indicated the claimant could not return to work at that time. On 02/20/07, Dr. placed the claimant at MMI with a 5% whole person impairment rating. On 03/14/07, Dr. requested lumbar surgery. On 03/20/07, Dr. wrote a preauthorization request for surgery. On 03/23/07 and 03/26/07, Ms. wrote letters of non-certification for the surgery.

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

Dr. is planning to use an unvalidated device called the Axialif. This has never subjected to any clinical trials and in fact, it has been implanted in only several hundred people in the world. This is not validated as a treatment for lumbar degenerative disc disease.

The second problem with this case is that the pain generator has never been established. This is an individual with multilevel degenerative disc disease. There are significant psychological and emotional issues. The claimant has changes visualized on the MRI from L2 to the sacrum. It is unclear how the decision was made to proceed with an operation at one level, rather than the others. In my opinion, the pain generator has not been adequately defined and surgery is less than likely to succeed. In my opinion, surgical treatment, including interbody fusion and discectomy at L5-S1, interbody fixation at L5-S1, posterior decompression at L5-S1, transverse process fusion at L5-S1, and a posterior internal fixation at L5-S1 with a one day length of stay, is neither reasonable nor necessary as related to the original injury.

Criteria for decision include the ODG Guidelines, as well as the North American Spine Society, Phase III, Clinical 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, Clinical Guidelines.