

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 05/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transverse posterior lumbar interbody fusion at L4-L5 and L5-S1 with a three 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

X-rays and an MRI of the lumbar spine interpreted by, M.D. dated 04/27/06
Prescription refills from, M.D. dated 05/02/06
A letter from, D.O. dated 05/18/06

Evaluations with Dr. dated 05/22/06, 06/07/06, 06/08/06, 06/20/06, 07/05/06, 08/25/06, 01/31/07, 02/06/07, 02/14/07, 03/09/07, 04/02/07, 04/09/07, and 04/12/07

Evaluations with, M.D. dated 05/31/06 and 06/06/06

Laboratory studies interpreted by, M.D. dated 05/31/06

Laboratory studies interpreted by an unknown provider (no name or signature was available) dated 06/02/06

Physical therapy with an unknown therapist (the signature was illegible) dated 06/05/06

A letter from Dr. dated 08/25/06

An MRI of the lumbar spine interpreted by, M.D. dated 01/31/07

A letter of non-authorization from dated 02/23/07

A Required Medical Evaluation (RME) with, M.D. dated 03/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays and an MRI of the lumbar spine interpreted by Dr. on 04/27/06 revealed mild degenerative changes and encroachment of the left L5-S1 neuroforamen. On 05/02/06, Dr. prescribed Prednisone, Relafen, and Skelaxin. On 05/22/06, Dr. recommended light work duty, an exercise program, medications, and possible surgery. On 05/31/06, Dr. ordered laboratory studies. Laboratory studies interpreted by Dr. on 05/31/06 revealed low prothrombin time. Laboratory studies interpreted by an unknown provider on 06/02/06 revealed high protein C and no lupus anticoagulant. Physical therapy was performed with the unknown therapist on 06/05/06. On 06/06/06, Dr. requested Lovenox and Coumadin after surgery. On 01/31/07, Dr. requested a repeat MRI. An MRI of the lumbar spine interpreted by Dr. on 01/31/07 revealed a 2 to 3 mm. disc bulge at L4-L5 and a 3 to 4 mm. disc herniation at L5-S1 with marked degeneration at L5-S1. On 02/06/07, 03/09/07, and 04/02/07, Dr. requested surgery. On 02/23/07, wrote a letter of non-authorization for surgery. On 03/14/07, Dr. felt surgery was indicated. On 04/09/07, Dr. continued to request surgery.

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

The patient has significant radicular symptoms. His residual axial pain can be treated with physical therapy. Not every individual with severe degeneration would require surgical fusion. In fact, the more severe the degeneration, the less likely they will require fusion. This individual does not show significant instability. The pain generator has not been identified. In my opinion as a board certified orthopedic surgeon, with a specialty in spinal diseases, the transverse posterior lumbar interbody fusion at L4-L5 and L5-S1 with a three-day length of stay is unnecessary.

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)**

The Spine, Simeon and Rothman.