

Notice of Independent Review Decision

DATE OF REVIEW: 08/12/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy, discectomy, foraminotomy and partial facetectomy at L3-4

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the lumbar laminectomy, discectomy, foraminotomy and partial facetectomy at L3-4 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter– 07/31/08
- Notice to Utilization Review Agent of Assignment of IRO – 07/31/08
- Information for requesting review by an IRO – 07/30/08
- Decision letter – 07/01/08, 07/17/08
- Report of review– 07/01/08
- PEER Review Report– 07/15/08

- Prior authorization request – 06/27/08, 07/14/08
- Letter from Dr. to Dr. – 12/13/07, 02/07/08
- Pre-surgical assessment– 02/27/08
- Initial Behavioral Medicine Consultation – 02/27/08
- WAC new patient evaluation – 02/18/08
- Request for reconsideration by Dr. – 07/14/08
- Comprehensive Re-Evaluation by Dr. – 11/12/07
- Report of MRI if the lumbar spine – 01/10/08
- Request for Medical Dispute Resolution from Dr. - 07/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was pulling a chain that got stuck. This exacerbated his symptoms of lower back pain. The patient is status post surgery on 06/16/05 when he underwent a lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L5-S1. An MRI of the lumbar spine performed on 01/10/08 indicates a left paracentral disc protrusion at L3-4. The patient is being treated with physical therapy and analgesics.

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

This patient manifests symptoms that are consistent with an L3-4 disc herniation as described by MRI and failed satisfactory conservative care of over six months duration. While a trial of epidural steroid injections would be a reasonable treatment option in this clinical setting, they are by no means mandatory prior to proceeding with appropriate surgery as proposed.

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)