



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 07/03/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator (EBI) at L5-S1 with a two 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.

Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator (EBI) at L5-S1 with a two length of stay – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Fire Department Emergency Medical Service Hospital Report form
An Air Life patient care report from R.N.,
CT scans of the cervical spine, head, pelvis, abdomen, and chest interpreted by Dr. (no credentials were listed)
A nursing note from an unknown nurse (signature was illegible)
An evaluation with an unknown physician (signature was illegible)
A medical necessity form from, M.D.
A medical record report
An inventory of personal effects report
A case manager note from R.N. dated 12/17/07
Evaluations with D.O. dated 12/17/07 and 12/19/07
DWC-73 forms from M.D. dated 12/17/07, 12/19/07, 12/26/07, 01/02/08, 01/08/08, and 01/14/08
A therapy flowsheet dated 01/14/08
Evaluations with P.A.-C. for Dr. dated 12/24/07, 01/02/08, 01/08/08, and 01/14/08
An evaluation with Dr. dated 12/26/07
Physical therapy with P.T. dated 12/26/07, 01/03/08, 01/07/08, 01/08/08, 01/10/08, 01/11/08, and 01/14/08
Patient referral forms from an unknown provider (no name or signature was available) dated 12/26/07 and 01/17/08
An undated request for a Designated Doctor
A letter from R.N.. dated 01/04/08
A supplemental report of injury from an unknown person (signature was illegible) dated 01/04/08
A physician activity status report from Mr. dated 01/14/08
Evaluations with D.C. dated 01/17/08, 01/25/08, 02/08/08, 02/18/08, and 04/24/08
A DWC-73 form from Dr. dated 01/17/08
A letter of authorization. dated 01/22/08
An MRI of the cervical spine interpreted by M.D. dated 02/01/08
Physical therapy with an unknown provider (no name or signature was available) dated 02/04/08, 02/06/08, 02/08/08, 02/11/08, 02/13/08, 02/15/08, 02/18/08, and 02/28/08
An authorization and reasonable and necessity form from Dr. dated 02/11/08
An EMG/NCV study interpreted by M.D. dated 02/12/08
A letter of medical necessity from Dr. dated 02/18/08
A durable medical equipment (DME) prescription from Dr. dated 02/18/08
Evaluations with M.D. dated 02/19/08 and 03/11/08
Evaluations with D.C. dated 02/20/08, 02/28/08, 03/31/08, and 05/16/08
An MRI of the lumbar spine interpreted by Dr. dated 02/25/08
A Functional Capacity Evaluation (FCE) with D.C. dated 02/25/08
A DWC-73 form from Dr. dated 02/28/08
A Designated Doctor Evaluation with D.O. dated 03/06/08
An FCE with D.C. dated 03/06/08
A letter of medical necessity from Dr. dated 03/11/08
Undated information regarding electrical muscle stimulation benefits

An EMG/NCV study interpreted by an unknown provider (no name or signature was available) dated 03/20/08

A letter of clarification from Dr. dated 03/21/08

An EMG/NCV study interpreted by D.O. dated 03/26/08

Evaluations with M.D. dated 04/02/08 and 06/06/08,

An initial diagnostic screen with M.S., L.P.C. dated 05/13/08

A letter of non-authorization, according to the ODG, from M.D. dated 06/02/08

A letter of non-authorization, according to the ODG, from M.D. dated 06/11/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

CT scans of the cervical spine, head, chest, pelvis, and abdomen interpreted by Dr. on xx/xx/xx revealed left posterior parietal scalp soft tissue swelling, subcutaneous air, and radiopaque foreign bodies. The remainder of the CT scans were unremarkable. On 12/26/07, Dr. recommended Ibuprofen, physical therapy, limited work duty, and a home exercise program. Physical therapy was performed with Mr. from 12/26/07 through 01/14/08 for a total of seven sessions. On 01/25/08, Dr. recommended chiropractic therapy three times a week for three weeks and an MRI of the cervical spine. An MRI of the cervical spine interpreted by Dr. on 02/01/08 revealed disc protrusions at C2-C3, C3-C4, C4-C5, and C6-C7 and a disc bulge at C5-C6. Physical therapy was performed with an unknown provider from 02/04/08 through 02/28/08 for a total of eight sessions. An EMG/NCV study interpreted by Dr. on 02/12/08 was unremarkable. On 02/18/08, Dr. wrote a letter of medical necessity for a therapeutic thoracic belt and wrist support brace, as well as a cervical pillow, analgesic cream, and a muscle massager. An MRI of the lumbar spine interpreted by Dr. on 02/25/08 revealed a herniated disc at L5-S1, disc protrusions at L3-L4 and L2-L3, and a disc bulge at L1-L2 and L4-L5. An FCE with Dr. on 02/25/08 revealed the claimant functioned in the light-medium physical demand level. On 02/28/08, Dr. felt the claimant was not at Maximum Medical Improvement (MMI). On 03/06/08, Dr. felt the claimant was at MMI at that time with a 5% whole person impairment rating. On 03/11/08, Dr. recommended surgery. On 03/11/08, Dr. wrote a letter of medical necessity for further use of an electrical muscle stimulator unit. An EMG/NCV study interpreted by Dr. on 03/26/08 revealed bilateral radiculopathy from L2 to L5 on the left and L4 to S1 on the right. On 04/02/08, Dr. recommended Vicodin, Flexeril, lumbar epidural steroid injections (ESIs), and further physical therapy. On 05/13/08, Ms. felt the claimant would be given a good prognosis for surgery. On 06/02/08, Dr. wrote a letter of non-authorization for spinal surgery. On 06/06/08, Dr. recommended Vicodin, Skelaxin, and transforaminal ESIs. On 06/11/08, Dr. wrote a letter of non-authorization for surgery.

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

The medical records provided for review, while indicating a lumbar radiculopathy, fail to document findings that would support a lumbar fusion. The ODG criteria for fusion includes a neurologic defect, which is not noted, segmental instability, which is not noted, primary mechanical back pain, which in this patient's case is mainly a radiculopathy, not primary mechanical back pain, revision surgery for failed previous operation, which is not the situation, infection, tumor or deformity, which is not the case, or after failure of two discectomies, same disc, none of which the medical records document as being present in this patient's medical history. Therefore, the requested lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator (EBI) at L5-S1 with a two length of stay is not reasonable or necessary.

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)