



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 06/20/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L3-S1 laminectomy, facetectomy, transforaminal interbody fusion, posterior and lateral, at L3-L4, L4-L5, and L5-S1 with cages and instrumentation

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.

L3-S1 laminectomy, facetectomy, transforaminal interbody fusion, posterior and lateral, at L3-L4, L4-L5, and L5-S1 with cages and instrumentation - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by M.D. dated 12/21/07
An evaluation with M.D. dated 03/31/08
An evaluation with M.D. dated 04/22/08
A letter of non-authorization, according to the ODG, from M.D. dated 05/06/08
Letters of non-authorization, according to the ODG, from Utilization Review Nurse dated 05/07/08 and 05/30/08
A letter from Ph.D. dated 05/23/08
A note from Dr. dated 05/27/08
A letter of non-authorization, according to the ODG, from M.D. dated 05/29/08
An undated preauthorization request
A note from R.N., Utilization Management Insurance, dated 06/06/08
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 12/21/07 revealed multilevel degenerative changes with disc herniations/extrusions at L3-L4, L4-L5, and L5-S1. On 03/31/08, Dr. recommended additional Vicodin and a neurosurgical evaluation. On 04/22/08, Dr. recommended lumbar spine surgery. On 05/06/08, Dr. wrote a letter of non-certification for lumbar surgery. On 05/07/08 and 05/30/08, Ms. wrote letters of non-authorization for the lumbar surgery. On 05/29/08, Dr. also wrote a letter of non-authorization for lumbar surgery.

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

The request from the treating physician, Dr. is for a decompression from L3-S1 with a posterior lateral fusion. The patient has been recommended to undergo decompression for the primary complaint of lower back pain. This is inappropriate. The patient's lower back pain is a degenerative condition that would not respond to decompressive laminectomy. The patient does not meet the criteria set forth by the ODG, including verifiable neurological findings or radicular pain pattern to justify the hemilaminectomy. Further, the patient does not meet the ODG criteria for fusion, including definitive instability to spondylolisthesis. Therefore, the requested L3-S1 laminectomy, facetectomy, transforaminal interbody fusion, posterior and lateral, at L3-L4, L4-L5, and L5-S1 with cages and instrumentation is neither reasonable nor 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)