

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 05/09/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Inpatient removal of hardware, lumbar laminectomy with instrumentation

**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 inpatient removal of hardware, lumbar laminectomy with instrumentation is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Decision letter– 03/12/08, 04/14/08
- Follow up note by Dr. – 12/06/06 to 02/20/08

- Report of CT lumbar spine – 02/14/08
- Report of myelogram – 02/14/08
- Copy of ODG Integrated Treatment/Disability Duration Guidelines – Low Back Problems
- Information for requesting a review by an IRO – 05/01/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient who had undergone an L4 to S1 spinal fusion with instrumentation in January of 2006 sustained a work related injury when she fell at work on xx/xx/xx and developed back pain radiating to the lower extremities. A CT myelogram of the lumbosacral spine indicates mild spinal stenosis at L3-L4 and neural foraminal stenosis at L3-L4 and L5-S1. This is causing impingement on the L3 and L5 nerve roots.

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

The proposed surgical treatment is medically appropriate in this clinical setting. The patient manifests symptoms that are classic for multi-factorial stenosis adjacent to a previous lumbar fracture. An EMG is not necessary to make this diagnosis. The myelogram/CT shows “worsening spondylosis at L3/L4 with increasing hypertrophic facet arthropathy and ligamentum flavum hypertrophy” as well as “decreased contrast within the L4 root sleeves”. Non-surgical management including physical therapy and pain management have failed to relieve the patient’s symptoms.

**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 KNOWLEDGBASE
- 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)**