

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy discectomy foraminotomy/partial facetectomy L4-5

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 neuro-surgeon 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/partial facetectomy L4-5 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO-03/31/09
- Notification of Determination – 02/12/09, 03/17/09
- IRO Request by Dr. - 06/30/09
- Letter from Dr. to Dr. – 01/27/09

- Office visit notes by Dr – 11/25/08,12/01/08
- Report of MRI of the lumbar spine – 11/05/08
- Preauthorization from Dr. – 02/04/09, 03/13/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was attempting to lift a patient into a wheelchair when she experienced an acute onset of low back pain with radiation into the bilateral lower extremities. An MRI of the lumbar spine revealed a herniated nucleus pulposus at L4-5. The patient has been treated with medications and physical therapy. The treating physician has recommended that the patient undergo lumbar laminectomy, discectomy, foraminotomy and partial facetectomy.

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

The patient's symptomatology, physical finding, failure of conservative care and MRI (as interpreted by the surgeon) all justify the proposed treatment. The presence or absence of possible adjacent level abnormalities on MRI has no bearing on the medical necessity of the proposed surgery.

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)