

Notice of Independent Review Decision

DATE OF REVIEW: 01/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient laminectomy with annular repair mesh interbody device lumbar (4-5)  
63030, 69990, 22851

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 orthopedic 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 inpatient laminectomy with annular repair mesh interbody device lumbar (4-5) 63030, 69990, 22851 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO
- Letter of determination – 12/22/08, 01/12/09

- Report of emergency department visit – xx/xx/xx
- Report of lumbar MRI – 07/17/08
- Office notes by Dr. – 09/08/08 to 12/12/08
- Report of lumbar x-rays – 06/25/08
- Procedure note for interpretation of lumbar epidurogram – 10/14/08
- Report of computerized muscle testing and range of motion – 12/12/08
- Laboratory studies from Hospital – xx/xx/xx06/24/08
- Report of CT scan of the brain – 06/25/08
- Discharge instructions from Hospital – xx/xx/xx
- Follow up Medical Report by Dr. – 10/27/08
- Initial Medical Report by Dr. – 07/02/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when she was on a ladder. She was shocked and fell back off the ladder, striking her head on the way down and landing on her buttocks. This resulted in injury with pain to her lower back. In addition, she complained of pain that radiates from her neck down between her shoulder blades. The patient has been treated with physical therapy, medications and epidural steroid injections.

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

This patient suffered an electric shock and fell from a ladder on xx/xx/xx. An MRI scan revealed central disc herniation and facet hypertrophy at L4-L5 and L5-S1 without mention of neural root compromise. Treatment has been non operative and standard. It has included medication, activity modification, physical therapy and epidural steroid injections without benefit. Physical findings have not confirmed radiculopathy. The MRI findings suggest degenerative disc disease without specific nerve root compressive compromise. Criteria for the performance of a laminectomy/discectomy as published in ODG, 2009 have not been met.

**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)