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Notice of Independent Review Decision

DATE OF REVIEW: 10/05/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360 degree fusion at L4-L5 and L5-S1 with a three day 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.

360 degree fusion at L4-L5 and L5-S1 with a three day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Laboratory studies dated 03/01/05 and 05/25/05

Evaluations with an unknown provider (signature was illegible) at dated 03/04/05, 03/24/05, 04/12/05, and 05/25/05
An MRI of the lumbar spine interpreted by , M.D. dated 03/08/05
An EMG/NCV study interpreted by , M.D. dated 05/10/05
A Functional Capacity Evaluation (FCE) with , P.T. dated 06/03/05
Evaluations with , M.D. at dated 07/11/05, 07/12/05, 07/13/05, 07/20/05, 07/29/05, 08/05/05, 08/12/05, 08/19/05, and 10/07/05
DWC-73 forms filed by Dr. dated 07/11/05, 07/12/05, 07/13/05, 07/20/05, 07/29/05, 08/05/05, 08/12/05, 08/19/05, and 10/07/05
Physical therapy with an unknown therapist (signature was illegible) dated 08/05/05, 08/08/05, 08/10/05, 08/12/05, and 08/17/05
Evaluations with , M.D. dated 10/19/05, 11/02/05, and 11/30/05
DWC-73 forms from Dr. dated 11/02/05 and 11/30/05
A Designated Doctor Evaluation with , D.O. dated 12/05/05
A letter from Dr. dated 12/09/05
A DWC-73 form from Dr. (no credentials were listed) dated 08/09/06
Evaluations with an unknown therapist (signature was illegible) dated 10/18/06, 02/15/07, and 01/21/08
Physical therapy with the same unknown therapist dated 10/24/06, 10/31/06, 11/08/06, 01/02/08, 01/03/08, 01/04/08, 01/08/08, 01/10/08, and 01/15/08
An MRI of the lumbar spine interpreted by , M.D. dated 08/21/06
An evaluation with an unknown provider (no name or signature was available) dated 09/27/06
A letter of certification, according to the Official Disability Guidelines (ODG), dated 01/22/08
Evaluations with , M.D. dated 12/18/08, 01/22/09, 02/25/09, 04/01/09, 05/14/09, 06/16/09, and 07/28/09
Case summary reports from , L.P.N. dated 12/26/08, 02/05/09, 06/22/09, and 06/30/09
A letter of certification, according to the ODG, from , M.D. dated 12/30/08
An MRI of the lumbar spine interpreted by , M.D. dated 01/15/09
An EMG/NCV study interpreted by , M.D. dated 01/15/09
A procedure note from Dr. dated 02/13/09
An evaluation with , M.D. for ., M.D. dated 03/06/09
A behavioral medicine evaluation/presurgical psychological screen with , L.P.C. and Ph.D. dated 03/25/09
A medication/treatment request review from , R.N. dated 06/02/09
A progress note from Ms. dated 06/16/09
A letter of non-certification, according to the ODG, from , M.D. dated 06/22/09
Letters of non-certification, according to the ODG, from , M.D. dated 06/30/09 and 08/24/09
A Notice of Independent Review Decision dated 07/23/09
An evaluation with Dr. dated 08/13/09
Patient information dated 08/14/09
A letter of non-certification, according to the ODG, from , M.D. dated 09/04/09
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 03/08/05 showed disc bulging and an annular tear at L5-S1 and disc desiccation at L4-L5. An EMG/NCV study of the lower extremities interpreted by Dr. on 05/10/05 showed evidence consistent with dorsal rami irritation of the L5-S1 nerve root bilaterally. On 07/20/05, Dr. recommended , physical therapy, an MRI, and modified work duty. Physical therapy was performed with an unknown provider at ECR from 08/05/05 through 08/17/05 for a total of five sessions. On 12/05/05, Dr. placed the patient at Maximum Medical Improvement (MMI) at that time with 5% whole person impairment rating. An MRI of the lumbar spine interpreted by Dr. on 08/21/06 showed intervertebral disc dehydration/degeneration at L4-L5 with mild inflammatory changes and mild intervertebral disc dehydration/degeneration at L5-S1. Further physical therapy was performed with the unknown therapist from 10/24/06 through 01/15/08 for a total of nine sessions. Another MRI of the lumbar spine interpreted by Dr. on 01/15/09 showed moderate degenerative disc disease with disc desiccation at L4-L5, as well as a 3 mm. disc protrusion. At L5-S1, there was moderate disc desiccation with a 4 mm. central disc protrusion. An EMG/NCV study of the right lower extremity interpreted by Dr. on 01/15/09 was unremarkable. Bilateral L4-L5 and L5-S1 facet injections were performed by Dr. on 02/13/09. On 03/06/09, Dr. recommended a lumbar discogram and a possible pain management program. On 03/25/09, Ms. and Dr. recommended anti-depressant medication. On 06/16/09, Ms. cleared the patient for a discogram. On 06/22/09, Dr. wrote a letter of non-certification for a discogram CT scan. On 08/24/09, Dr. wrote a letter of non-certification for a 360 fusion at L4-S1. On 09/04/09, Dr. also wrote a letter of non-certification for the surgery.

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

The patient had a low energy lifting injury and he has no instability. He has mild degenerative changes. He was noted to have significant depression and even after being treated with anti-depressants still had symptoms of anhedonia, decreased appetite, and other significant physical symptoms of depression. While the patient was “cleared” by a psychologist, this was a psychologist employed by the surgeon’s multidisciplinary group. Based on the objective evidence in the records, the patient is at significant risk for not improving after his surgery. Further, current scientific evidence reveals surgery based solely on discography, such as in this case, is only successful 50% of the time. For all these reasons, the patient does not meet the ODG criteria for a lumbar fusion.

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)**