Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 9/7/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a decompression lumbar laminectomy, discectomy, Arthrodesis, internal fixation at L4-5 and L5-S1 with use of a bone growth stimulator.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a decompression lumbar laminectomy, discectomy, Arthrodesis, internal fixation at L4-5 and L5-S1 with use of a bone growth stimulator.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
MD
Fire Insurance

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Fire Insurance: Dr. Pre-authorization request – 8/4/09, Office Visit Notes – 10/7/08-7/28/09; URAC IRO Decision – 4/9/09; DC Notes – 4/28/08-7/21/09; DC Second Opinion – 2/27/09; Case Management Note

– 3/23/09 & 4/27/09; PA.C Follow-up Note – 3/17/09; Surgery Center Procedure Note – 4/28/09 & 7/17/09; MD Office Notes – 6/16/09; MD MRI report – 9/24/08; MD EMG.NCS report – 10/30/08; M.S., L.P.C. Presurgical Screening – 11/26/08. Records reviewed from MD: Pre-authorization appeal request – 8/10/09; Surgery Codes – undated.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old male. He was injured when he fell while stepping onto scaffolding. An MRI on 9/24/08 showed a 3mm HNP at L4-5 and a 6mm central HNP at L5-S1 with thecal sac impingement. Flexion extension films reveal a 7mm retrolisthesis and a 25° excursion. The patient has not improved with bracing, physical therapy, or ESIs. He has undergone psychological testing and was felt to be an appropriate surgical candidate.

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

According to the ODG: **Patient Selection Criteria for Lumbar Spinal Fusion:** Functional Spinal Unit Failure/Instability, including one or two level segmental failure

Pre-Operative Surgical Indications Recommended: all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

This patient meets the ODG guidelines for this procedure. Therefore, the procedure is approved based upon the records provided.

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)**