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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/14/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy, discectomy, and fusion at L4-L5 and L5-S1 with a one 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.

Laminectomy, discectomy, and fusion at L4-L5 and L5-S1 with a one day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with , Ph.D. dated 05/20/08
An MRI of the lumbar spine interpreted by , M.D. dated 05/21/08
Evaluations with , M.D. dated 05/29/08, 06/23/08, 06/24/08, 07/07/08, 07/21/08, 07/29/08, 08/05/08, 08/19/08, 09/22/08, 10/07/08, 10/20/08, 11/13/08, 12/30/08, 02/03/09, 03/03/09, 03/24/09, 04/14/09, 05/26/09, 07/07/09, and 07/28/09
Medication prescriptions from , M.D. dated 06/05/08
X-rays of the lumbar spine and pelvis interpreted by M.D. dated 06/06/08
A letter from Dr. dated 06/11/08
X-rays of the chest interpreted by , M.D. dated 07/21/08
An operative report from Dr. dated 07/25/08
Evaluations with , D.C. dated 08/08/08, 09/09/08, and 10/24/08
DWC-73 forms from Dr. dated 09/09/08, 09/23/08, 10/24/08, 12/01/08, 12/17/08, 01/16/09, 02/16/09, 03/16/09, 04/14/09, 05/12/09, 06/18/09, 07/20/09, 08/08/09, and 08/21/09
Chiropractic therapy with Dr. dated 09/23/08, 12/01/08, 12/17/08, 01/16/09, 02/16/09, 03/16/09, 04/14/09, 05/12/09, 06/18/09, 07/20/09, and 08/21/09
A progress summary from Dr. dated 11/20/08
An MRI of the lumbar spine interpreted by , M.D. dated 12/08/08
Individual therapy with , B.S.D., L.C.D.C. dated 02/03/09, 02/10/09, 02/16/09, 02/23/09, 03/03/09, and 03/09/09
An evaluation with an EMG/NCV study with , M.D. dated 03/02/09
A request letter from Dr. dated 03/26/09
A letter of non-certification, according to the Official Disability Guidelines (ODG), from , R.N. dated 07/15/09
An appeal request from Dr. dated 07/31/09
A letter of non-certification, according the ODG, from , M.D., dated 08/06/09
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 05/21/08 showed multilevel spondylosis with a disc herniation at L4-L5 and L1-L2. On 05/29/08, Dr. recommended lumbar spine surgery, but noted the patient wanted physical therapy first and prescribed Vicodin and Fexmid. X-rays of the lumbar spine interpreted by Dr. on 06/06/08 showed L5-S1 spondylosis with severe disc space narrowing. On 06/11/08, Dr. recommended aquatic therapy and articular facet blocks. Lumbar spine surgery was performed by Dr. on 07/25/08. Chiropractic therapy was performed with Dr. from 09/23/08 through 08/21/09 for a total of 11 sessions. An MRI of the lumbar spine interpreted by Dr. on 12/09/08 showed disc protrusions at L1-L2 and L4-L5 with disc space narrowing at L4-L5 and L5-S1. Individual psychotherapy was performed with Mr. from 02/03/09 through 03/09/09 for a total of six sessions. On 02/03/09, Dr. provided a prescription to the for aquatic exercises. An EMG/NCV study interpreted by Dr

on 03/02/09 revealed chronic left L5 and S1 radiculopathy. On 03/26/09, Dr. recommended 10 sessions of a chronic pain management program. On 05/26/09, Dr. recommended walking shoes, Lidocaine patches, Vicodin, and glucosamine. On 07/15/09, Ms. wrote a letter of non-certification for lumbar surgery. On 08/06/09, 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 does not meet any of the criteria for the requested surgery. The patient does not have a definitive diagnosis of radiculopathy. The electrodiagnostic findings are chronic in nature and these types of findings could be found after any sort of surgical intervention. The MRI after surgery does not demonstrate significant neural compression and in fact demonstrates a complication of the surgery; that is the pseudomeningocele.

Further, the patient does not meet several of the ODG criteria for fusion. All of the pain generators have not been established. The patient does not have instability or any objective indication for fusion. The patient has not had a psychological evaluation. For these reasons stated above, the requested laminectomy, discectomy, and fusion at L4-L5 and L5-S1 with a one day length of stay would be neither reasonable nor necessary and the previous adverse determinations should be upheld.

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
- X 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)