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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 08/23/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Decompression and fusion at L2-L3

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.

Decompression and fusion at L2-L3 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRIs of the lumbar spine interpreted by, M.D. dated 12/17/92 and 09/21/04
X-rays of the lumbar spine interpreted by, D.O. dated 11/11/01
An MRI of the lumbar spine interpreted by, M.D. dated 10/02/03
An MRI of the lumbar spine interpreted by, M.D. dated 03/28/07
An MRI of the lumbar spine interpreted by M.D. dated 09/19/09
An evaluation and EMG/NCV study with M.D. dated 09/22/09
Evaluations with M.D., a neurosurgeon, on 05/03/10 and 05/24/10
X-rays of the lumbar spine interpreted by Dr. dated 05/03/10
A lumbar myelogram CT scan interpreted by M.D. dated 05/20/10
Laboratory studies dated 05/20/10
Peer reviews from M.D. dated 06/09/10 and 07/15/10
A letter of denial, according to the Official Disability Guidelines (ODG), from dated 06/10/10
A preauthorization request from C.P.C. dated 07/12/10
A letter of denial, according to D.O. at according to the ODG, dated 07/15/10
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 12/17/92 showed degenerative changes and annular bulging at L3-L4 and L4-L5. X-rays of the lumbar spine interpreted by Dr. dated 11/11/01 showed degenerative arthritis of the lower lumbar spine with postoperative changes. An MRI of the lumbar spine interpreted by Dr. dated 10/02/03 showed postsurgical changes at L4-L5 with a partial discectomy and posterolateral solid appearing fusion. An MRI of the lumbar spine interpreted by Dr. on 09/21/04 showed degenerative changes at L2 through L5, an annular bulge at L2-L3, and mild annular bulging at L3-L4. An MRI of the lumbar spine interpreted by Dr. on 03/28/07 showed small oval areas in the vertebra very slightly progressed since 09/21/04, irregularity and mild enhancement in the left iliac bone, degenerative changes at L2 through L5, and mild annular bulging at L2-L3 and L3-L4. An MRI of the lumbar spine interpreted by Dr. on 09/19/09 showed mild degenerative disc disease at L3-L4 and L4-L5. An EMG/NCV study with Dr. on 09/22/09 was unremarkable. A lumbar myelogram CT scan interpreted by Dr. on 05/20/10 showed postsurgical changes with a probable interbody fusion and discectomy changes at L4-L5 with arthrodesis from L4 through S1 and multilevel lumbar spondylosis and degenerative

changes. On 05/24/10, Dr. recommended a lumbar spinal decompression and extension of the arthrodesis cephalad at L2-L3. On 06/10/10, wrote a letter of denial for a decompression and fusion at L2-L3. On 07/15/10, Dr. wrote a letter of denial for the surgery.

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

The patient has a fusion at L4-L5. There is no evidence of instability. There are multilevel degenerative disc changes. There is no evidence of instability. There is no evidence that a fusion will change the patient's chronic pain complaints, which according to the treating physician have been present for 15 years.

The ODG does allow for fusion in some circumstances. Adjacent level degenerative changes where there is no evidence of instability, is not one of them. At the current time, it is not reasonable or necessary to perform the surgery that Dr. is recommending. It is unlikely to improve the patient's clinical condition. Therefore, the requested decompression and fusion at L2-L3 is 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**
- 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)**