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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 13, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assis (63030) and 2 day LOS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	LOS		Prosp	2					Upheld
724.2	63030		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 83 pages of records received to include but not limited to: Group letters 6.1.10-11.22.10; TDI letter 11.22.10; Request for an IRO forms; report 9.21.10, 10.5.10; records from Dr. 4.15.10-10.1.10; MRI Lumbar spine 5.3.10; records Dr. 8.4.10; Physical Therapy and Rehab notes 7.15.10 and FCE 7.2.10; Solutions report 5.27.10; report 3.22.10

Requestor records- a total of 29 pages of records received to include but not limited to: Records from Dr. 4.15.10-7.20.10; MRI Lumbar spine 5.3.10; records Dr. 8.4.10

PATIENT CLINICAL HISTORY [SUMMARY]:

The pre-authorization request from September 21, 2010 was for a three level lumbar fusion. That request was not certified. The reconsideration was for a laminotomy and decompression with partial facetectomy and excision of a disc lesion. The rationale was addressing a lumbar fusion. This reconsideration was also not certified.

The fax cover sheet from Dr. office was seeking certification for a 360° fusion at three levels. The June 10, 2010 progress notes indicated that epidural steroid injections, work hardening and other conservative measures were to be attempted. The past medical history is significant for a three level disc procedure nine years prior. MRI dated May 3, 2010 noted disc lesions at L3/4, L4/5 and L5/S1 associated with facet arthropathy and other degenerative changes.

Dr. completed a neurologic evaluation and noted low back pain and a long history of radiculopathy. There were co-morbidities of hypertension and diabetes. Electrodiagnostic studies noted chronic L4/5 radiculopathy only.

A pre-surgical physical therapy evaluation was completed tempered with a July 2, 2010 Functional Capacity Evaluation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines multi-level fusion procedures, or three level laminotomy procedures are not supported , particularly at three levels. Further, the indicators for a fusion (instability, infection or fracture) are not present. Therefore, medical necessity could not be established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES