

Notice of Independent Review Decision

DATE OF REVIEW: 01/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One day length of stay for lumbar laminectomy at L2-3, L3-4, 63047 63048

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the one day length of stay for lumbar laminectomy at L2-3, L3-4, 63047 63048 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/21/09
- Adverse determination letter from– 11/30/09, 12/14/09
- Report of x-rays of lumbar spine – 05/15/08
- Report of MRI of the lumbar spine – 06/11/08
- Designated Doctor Evaluation by Dr.– 09/17/09
- Functional capacity evaluation – 09/21/09
- Office visit notes by Dr.– 05/16/08 to 11/25/09

- Office visit notes by Dr.– 09/16/09 to 11/20/09
- EMG and NCV consultation by Dr.– 10/15/09
- Copy of ODG Treatment/Disability Guidelines for Low Back-Lumbar & Thoracic – printed 12/22/09
- Operative report by Dr.– 07/28/09
- Report of CT of the lumbar spine post myelogram – 04/12/09
- Report of lumbar myelogram – 03/26/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was raising an over head door that was stuck. This resulted in immediate severe pain from the low back to the left leg. He has been diagnosed with herniated nucleus pulposus at L2-3 and L3-4 with persistent radiculopathy. He has been treated with medications and epidural steroid injections. This patient continues to complain about pain in his low back area and has had studies to include MRI and CT myelogram as well as EMG studies. The treating physician is recommending surgical intervention.

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

The physical examination on this patient shows that he has positive straight leg raising and he has back pain with limitation of motion. However, he has no signs of atrophy in his lower extremities. He does have equal reflexes, which are present and no signs of any decrease of ankle, knee, or patellar reflexes. There is no real impingement or significant spinal stenosis caused from the bulging of the disc at L2-L3 or L3-L4. The patient does not have any foraminal encroachment at the L3-L4 level. There is some minor to moderate disc protrusion at L2-L3. He did have a CT myelogram, which shows there were degenerative disc disease at the L4-L5 and L5-S1 area and he had evidence of some mild neurologic deficit on EMG, but this was at the L5-S1 area. This patient has continued to have difficulty but there are inconsistent findings as compared to the physical examination. There is a recommendation for surgery at L2-L3 and L3-L4 levels. This patient does not meet the requirement for surgery with the inconsistent level. In addition, there is no real sign of atrophy. In essence, this is a patient who has back pain and some leg pain with inconsistent findings. Operating on the L2-L3 and L3-L4 levels when there is pathology at L5-S1 levels is not consistent with getting a good result. This patient at this time is not a candidate and does not meet requirements in the ODG or AMA guidelines for this surgical procedure. Therefore, it is determined that the surgery is not indicated at this time.

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)