

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: JULY 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar laminectomy/discectomy @ L4-5,L5-S1
(63030, 63035, 69990, 22612, 22614, 22851, 20938, 22842, 22558, 22585, 63685, 22325, 22328, 20975, 99221)

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 |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|------------|--------------|
| 722.10,724.6 | 63030 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 63035 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 69990 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22612 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22614 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22851 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 20938 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22842 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22558 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22585 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 63685 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22325 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 22328 | | Prosp | 1 | | | | | Upheld |
| 722.10,724.6 | 20975 | | Prosp | 1 | | | | | Upheld |

| | | | | | | | | | |
|--------------|-------|--|-------|---|--|--|--|--|--------|
| 722.10,724.6 | 99221 | | Prosp | 1 | | | | | Upheld |
|--------------|-------|--|-------|---|--|--|--|--|--------|

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a notice of adverse determination for a lumbar laminectomy/discectomy with an anterior lumbar arthrodesis (aka fusion). There was a reconsideration of this request completed by Dr. that also did not certify the request. Dr. noted that the requesting provider saw the injured employee twice, made a reference to instability and this determinations was not supported by the objective data reviewed.

The progress notes from the requesting provider noted on March 23, 2010 again indicating that he believes that there is a clinical instability. Surgical fusion was sought.

Electrodiagnostic studies noted a radiculitis and not a radiculopathy. CT scan of the lumbar spine reported no fractures, antral or retrolisthesis, no degenerative changes and no disc bulges.

The physical therapy and psychiatry evaluations and notes are reviewed. The lumbar MRI noted a 3mm disc bulge at two levels, facet joint hypertrophy and spondylosis. There was no evidence of acute injury reported.

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/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines the criteria for a lumbar fusion surgery are:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include:

1. Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia
2. Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. ([Andersson, 2000](#)) ([Luers, 2007](#))]
3. Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with

progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. ([Andersson, 2000](#))]

4. Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature.
5. Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.
6. After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria.

Add to this that the Designated Doctor noted maximum medical improvement with a 0% whole person impairment rating and there is no surgical indication based on the medical records.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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