



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 06/02/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior Lumbar Decompression/Fusion at L4-L5 with one to two days LOS

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

Orthopedic Surgeon

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.

Posterior Lumbar Decompression/Fusion at L4-L5 - OVERTURNED
One to two days LOS - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI Lumbar Spine, M.D., 06/20/08
- Evaluation, M.D., 02/09/10
- MRI Lumbar Spine, M.D., 03/05/10
- Office Visit, Dr., 03/11/10, 04/22/10
- X-Ray Lumbar Spine, Dr., 03/12/10
- Reconsideration Request, Spine & Neurological Surgery Institute, Undated
- Denial Letter, 04/01/10, 04/21/10
- Behavioral Evaluation, M.A., L.P.C., 04/12/10
- Pre-Authorization Request, Spine & Neurological Surgery Institute, Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured his low back while lifting a lead pine. An MRI from 2008 showed increased lumbar lordosis associated with changes of degenerative spondylotic process in a generalized manner. A disc herniation at L4-L5, central in location, moderate in degree and associated with bilateral nerve root impingement was also noted. There was also an early disc bulging at level L5-S1. Another MRI performed in 2010 showed degenerative changes with marked spinal stenosis at L4-L5 level and minimal spondylolisthesis at L4-L5, as well as bilateral foraminal narrowing. The patient was started on Benicar 40 mg, Metformin HCL 500 mg and Ibuprofen 800 mg. It was noted in the medical documentation that the patient was also treated with Epidural Steroid Injections (ESIs), physical therapy, and medial supportive care.

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

In my opinion, the posterior lumbar decompression/fusion at L4-L5 with one to two days is medically reasonable. The rationale is ODG criteria for laminotomy/laminectomy for spinal stenosis, which is what is being treated here, and includes the criteria under discectomy/laminectomy, with except for criterion number one of findings for a radiculopathy, and with spinal stenosis those findings are not routinely present. In line with ODG criteria are imaging findings which the patient does have, and in line with ODG criteria of findings of prior treatment including epidural steroid injections, medications, physical therapy, and psychological screening, and the patient's medical records all document such findings. The patient's history documents a spinal stenosis type of complaint. Therefore, at this time the surgical procedure is medically necessary and within ODG criteria for laminectomy/laminotomy, which is the appropriate procedure for spinal stenosis, which is what is being treated at L4-L5. The one-day to two-day is within ODG criteria for length of stay.

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)