

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 01/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 laminectomy, discectomy, discography, fusion with instrumentation, and a 2 day stay using CPT codes 63030, 63035, 62290, 69990, 22612, 22851, 20938, 22325, 22558 and 22840

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 L5-S1 laminectomy, discectomy, discography, fusion with instrumentation, and a 2 day stay using CPT codes 63030, 63035, 62290, 69990, 22612, 22851, 20938, 22325, 22558 and 22840 are medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/30/09
- Decision letter from – 12/14/09, 12/22/09, 12/28/09
- Office visit notes from Dr. – 09/22/09
- Psychological Reassessment by Dr. – 12/26/07
- Patient follow up notes from Systems – 07/27/09 to 08/17/09
- Initial Patient Evaluation by Systems – 04/30/09
- Orthopedic office notes by Dr.– 02/06/07 to 02/03/09
- Physician Review Recommendation by Dr. 0 12/02/09, 12/14/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was lifting a package of sheets when she felt her back snap. The patient has been diagnosed with lumbar herniated nucleus pulposus with discogenic pain and radiculopathy with clinical instability at L5-S1 with failure of conservative care. She has undergone provocative discography and has been treated with an exercise program, medications, epidural steroids and facet joint injections. The treating physician has recommended surgical intervention.

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

This patient underwent x-rays of the lumbar spine with flexion and extension views that revealed a shift of the L5-S1 with stenosis and narrowing of disc and there was a lateral release of some 7mm extension, which corrected with flexion. The patient also had a previous positive EMG which confirmed the diagnosis of radiculopathy. Her physical examination on 09/22/09 showed that she had a positive straight leg raising test. She had an extensor lag. Positive Lesegue, and marked tenderness. The patient had a positive Lasegue on the right, decreased ankle reflex and absent posterior ankle reflex, paresthesias along the L5-S1 nerve root. It was felt that a fusion of L5-S1 due to the instability and decompression of the nerve root would be necessary. The patient does meet the criteria as the ODG states that she does have instability at the lumbar, at the L5-S1 area, which is demonstrated on x-rays. She does have evidence of disc space problems with radiculopathy, which were confirmed by MRI and also EMG and nerve conduction studies. The patient had a psychological work up and there is no documented reason that she would not improve with a surgical

intervention. Since she does meet the ODG criteria for surgery, it is determined that the surgical procedure as described is medically indicated.

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)