

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed disectomy and fusion L5-S1 w/3 day LOS (63030, 22630, 22612, 22840)

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
722.2	63030		Prosp	1					Upheld
722.2	22630		Prosp	1					Upheld
722.2	22612		Prosp	1					Upheld
722.2	22840		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-21 pages

Respondent records- a total of 58 pages of records received to include but not limited to:

Provider list; letter 8.2.10, 8.13.10; Medical Center, MRI Lumbar spine 3.18.05; EMG test 6.6.05; Hospital operative report 2.6.06; Lumbar Myelogram 11.15.05; CT Lumbar spine 11.15.05, 2.6.06; Chiropractic note 1.24.07; ROM test 1.26.07; MRI Lumbar spine 3.20.09; Orthopedics notes 3.1.10-6.11.10; BHI2 Enhanced Interpretive report 4.26.10; note 5.26.10; ODG guidelines Lumbar and Thoracic

Requestor records- a total of 117 pages of records received to include but not limited to:

M.D. notes 3.1.10-6.11.10; M.D. notes 10.11.05-1.11.10; Spine Care notes 4.27.05-3.22.06; Dr. notes 1.6.06-4.14.06; Chiropractic clinic notes 4.25.05-3.10.06; DWC forms 69; BHI2 Enhanced Interpretive report 4.26.10; Texas letter 3.9.10; ODG guidelines for Psychological screening; Assessments for Clinical and Psychological use regarding BHI2; x-ray L spine; FCE 9.22.06, 10.18.05; PPE report 4.28.06; ROM test 3.10.06; Lumbar Myelogram 11.15.05; MRI Lumbar spine 9.9.05; MCV study 5.16.05; Hospital operative report 2.6.06

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the letter of non-certification for the requested procedure. The reported mechanism of injury was turning a 15 inch hand crank and sustaining low back pain. Prior interventions included lumbar epidural steroid injections and the lumbar rhizotomy. The reviewer comments indicated there is no clear clinical indication of a radiculopathy to support the requested procedure. A reconsideration was filed and again not certified for a lack of a clinical indication.

The lumbar MRI dated March 18, 2005 noted degenerative changes. The electrodiagnostic assessment completed, June 6, 2005 noted a bilateral L5 radiculopathy. Another epidural steroid injection was completed on October 3, 2005. A lumbar myelogram was completed on November 15, 2005. There was no obvious disc herniation. This was completed on February 6, 2006 noting concordant pain at the L5/S1 level. However, CT scan completed the same day, was a normal examination of the lumbar spine. Maximum medical improvement was noted as of February 7, 2007 and a 10% whole person impairment rating was assigned.

A repeat MRI of the lumbar spine was completed on March 20, 2009. And there was no focal disc abnormality identified. A psychiatric evaluation was completed.

The June 11, 2010 report from Dr. noted that the injured worker followed up for injury dating back to January 26, 2005. There was increased low back pain noted. There is some lower extremity weakness noted. There was tenderness to palpation on physical examination. And there was a reference to the myelogram, which noted concordant disc pain and abnormal nuclear morphology. However, the MRI was normal. Dr. was seeking a lumbar fusion both anterior and posterior.

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 lumbar fusion is indicated only as an option for "spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise." None of these maladies is noted in this case. When noting the patient selection criteria for a lumbar spinal fusion identified in the Official Disability Guidelines (updated August 30, 2010). None of this criterion has been objectified. There is no neural arch defect, segmental instability, excessive motion or motion segment integrity loss, as defined by the AMA Guides. There is no infection, tumor, deformity or failure of prior surgery. Simply put, there is no clear clinical indication for the requested procedure.

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
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)