

Notice of Independent Review Decision

DATE OF REVIEW: 03/30/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar diskectomy with fusion.

Laminotomy, Single Lumbar 63042
Lumbar Spine Fusion 22612
Lumbar Spine Fusion 22630
Insert Spine Fixation Device 22840
Apply Spine Prosth Device 22851
SP Bone ALGRFT Struct Add-on 20931
SP Bone AGRFT Local Add-on 20936

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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.

Non-certified: Upheld

Based on the clear lack of objective evidence of radiculopathy and in the absence of definitive imaging studies that verify the presence of a recurrent disk herniation, the request for a left-sided lumbar diskectomy and L5-S1 fusion is not considered medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 17 page fax 3/11/11 IRO request, 3 Faxes: 82 pages, 84 pages and 81 pages dated 3/15/11 URA response to disputed services including administrative and medical records. 20 page fax 3/23/11 Provider response to disputed services including administrative and medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a XX-year-old male who was injured in a motor vehicle collision XX/XX/XX. I have reviewed the medical records available to me, including the treating physician's office notes most recently dated 01/05/11 along with reviews performed by Dr. dated 01/14/11 and dated 03/03/11.

From the medical records reviewed, it is apparent that since the motor vehicle collision patient has suffered from complaints of lower back pain and occasional left leg pain. According to the treating physician's records on 01/05/11, the patient had complaints of lower back pain and some left leg pain along with some left leg numbness and tingling. There were also complaints of difficulty walking. Dr. notes indicate the patient has had two prior back surgeries "with very little improvement." The patient's pain is reportedly relieved with medications moderately as well as exhibiting moderate relief with rest. Dr. notes further indicate no evidence of motor weakness, sensory deficits, or other neurologic abnormalities that would establish the diagnosis of lumbar radiculopathy.

The MRI of the lumbar spine, which was performed on 11/04/10, revealed degenerative disk disease at L4-5 and L5-S1 along with the partial laminectomy defect on the left side at L5-S1. There was thought to be a focal left paracentral epidural soft tissue suggesting recurrent disk herniation versus scar tissue. However, this was an MRI without contrast. The radiologist opined that recurrent disk herniation was "more likely." There was moderate narrowing of the left lateral recess and bilateral neural foramina at the L5-S1 level with possible impingement of the left S1 traversing nerve root. There were reportedly no additional areas of likely nerve root compression.

The patient additionally underwent a psychological evaluation of 02/19/11, and from a psychological standpoint, the patient was cleared for surgical treatments.

Based on the information presented, the provider had recommended a left-sided diskectomy and fusion of L5-S1.

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

Based on the clear lack of objective evidence of radiculopathy and in the absence of definitive imaging studies that verify the presence of a recurrent disk herniation, the request for a left-sided lumbar discectomy and L5-S1 fusion is not considered medically necessary.

ODG:

Official Disability Guidelines, Chapter: Low Back, Discectomy/Laminectomy as well as the section for Lumbar Spine Fusion.

**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)