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Notice of Independent Review Decision

DATE OF REVIEW: 8-17-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a lumbar laminectomy instrumentational inter body fusion w/bone graft

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the lumbar laminectomy instrumentational inter body fusion w/bone graft

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The records were received and reviewed. The claimant was noted to have been injured in xx/xx/xx. The claimant has been documented as having low back pain with radiation into the left leg. He has been noted to have paraspinal and sciatic notch tenderness and restricted spinal range of motion in addition to a bilateral positive straight leg raise, left more positive than right. The neurological exam in the extremities has been noted to otherwise be normal. The condition has been noted to have persisted despite medications, epidural steroid

injections and nerve root blocks, along with physical therapy. An MRI scan dated 5-26-10 revealed, as per the radiologist's report, a disc protrusion at L5-S1 (central and left-sided) along with an annular fissure and mild stenosis. Electrical studies dated 3-23-2011 revealed lumbar radiculopathy. Denial letters noted the lack of segmental instability on x-rays and lack of psychosocial clearance and response to ESIs and/or PT. On 3-16-2011, the FCE revealed that the claimant met the medium level requirements of his occupation.

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

Recommend non-authorization of the requested service. The lack of segmental instability (as typically would be demonstrable on lateral flexion-extension x-rays) and lack of psychosocial clearance reflect that the claimant has not met ODG criteria for decompression and fusion in combination. Specifically, fusion in itself warrants such a psychosocial screen and evidence of pain generation from the segment associated with radiculopathy. Therefore, the applicable guideline criteria have not been met. The proposed procedures are not reasonable or necessary as a combined aggregate/as requested.

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)