



Notice of Independent Review Decision

OLDATE OF REVIEW: 12/06/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

22558 Anterior Lumbar Interbody Fusion @ T11-T12
22851 Spinal Prosthetic Device
22610 Interbody Thoracic Fusion @ T11-T12
63046 Removal Spinal Lamina
63048 Additional Level
22840 Spine Fixation Device
95920 Intra-operative Nerve Test Add On
95926 Intra-operative Somatosensory Testing
20902 Removal Bone Graft
77002 Fluoroscopy
38220 Bone Marrow Aspiration
95937 Neuromuscular Junction Test
99221 Inpatient Hospitalization: 2 Days

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

Board Certified in Orthopaedic Surgery
Certified in Evaluation of Disability and Impairment Rating -
American Academy of Disability Evaluating Physicians

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.

22558 Anterior Lumbar Interbody Fusion @ T11-T12 – UPHELD

22851 Spinal Prosthetic Device – UPHELD

22610 Interbody Thoracic Fusion @ T11-T12 – UPHELD

63046 Removal Spinal Lamina – UPHELD

63048 Additional Level – UPHELD

22840 Spine Fixation Device – UPHELD

95920 Intra-operative Nerve Test Add On – UPHELD

95926 Intra-operative Somatosensory Testing – UPHELD

20902 Removal Bone Graft – UPHELD

77002 Fluoroscopy - UPHELD

38220 Bone Marrow Aspiration – UPHELD

95937 Neuromuscular Junction Test – UPHELD

99221 Inpatient Hospitalization: 2 Days – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury or Illness, xx/xx/xx
- Associate Statement, 04/01/10
- Evaluation, Center, 04/01/10
- Progress Note, M.D., 04/01/10, 04/08/10, 04/12/10
- DWC Form 73, Dr. 04/01/10, 04/08/10, 04/12/10, 04/19/10
- Initial Evaluation/Plan of Care, P.T., 04/07/10
- Treatment Encounter Note, P.T., 04/07/10
- MRI, Health, 04/09/10
- Lumbar Spine MRI, Health, 04/09/10
- Evaluation, M.D., 04/19/10
- Physical Therapy Discharge Summary, P.T., 04/30/10
- Peer Review, N.F. M.D., 05/05/10
- Thoracic MRI, MRI Center 05/06/10
- Cervical MRI, MRI Center 05/06/10
- Lumbar MRI, MRI Center 05/06/10
- Follow Up, Dr. 05/10/10
- History and Physical, D.O., 06/30/10
- Follow Up, Dr. 07/20/10, 08/25/10, 10/08/10, 10/27/10, 12/14/10, 01/14/11, 03/17/11
- DWC Form 73, Dr. 07/20/10, 08/25/10, 10/08/10, 10/27/10, 12/14/10, 03/17/11
- History and Physical Neurologic Consultation, M.D., 12/01/10

- Consultation, P.A., 03/01/11, 04/11/11, 08/29/11
- Injection for Myelogram, Medical Center, 03/28/11
- Myelogram Lumbar, Medical Center, 03/28/11
- CT Lumbar Spine, Medical Center, 03/28/11
- Evaluation, M.D., 04/15/11, 05/16/11, 07/12/11, 08/16/11, 09/16/11, 10/17/11
- DWC Form 73, Dr. 04/15/11, 05/16/11, 07/12/11, 08/16/11, 09/16/11, 10/17/11
- Neurological Follow Up, Dr. 04/20/11
- Pre-Surgical Behavioral Medicine Consultation, Injury 1, 04/20/11
- Lumbar Spine X-Rays, Medical Center, 07/11/11
- Prior Authorization Request, 07/29/11, 10/14/11, 10/31/11
- Thoracic Spine X-Rays, Medical Center, 09/12/11
- Lumbar Spine X-Rays, Medical Center, 09/12/11
- Denial Letters, 10/19/10, 11/07/11
- Letter of Reconsideration, 10/31/11
- Summary Letter to the IRO, Dr., 11/14/11
- The ODG Guidelines were not provided by the carrier or the URA.

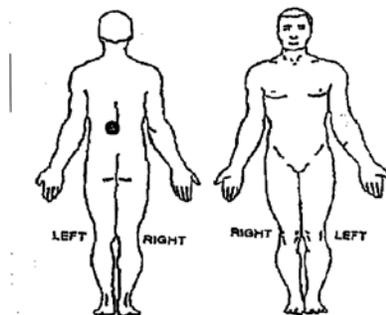
PATIENT CLINICAL HISTORY (SUMMARY):

The patient was a female with bipolar disease who lifted a heavy television hutch and felt a catch in her lower back. An MRI dated xx/xx/xx demonstrated a large left paracentral extruded disc herniation at T11-T12 with compression of the conus. M.D. pointed out on 04/12/10 this “really does not go along with her symptoms well”. Subsequent examinations failed to demonstrate long tract signs or evidence of symptomatic cord compression. After thoracic decompressive surgery was proposed by, M.D. and not authorized, M.D. opined the symptoms “suggest more of a L5 radiculopathy on the right”. Dr. (the current requesting neurosurgeon) documented symmetric reflexes and a “sensory examination reveals a T10 sensory level to pin prick and light touch and decrease to pin prick and light touch in the right lower extremity throughout in a non-dermatomal distribution” acknowledging “no saddle anesthesia was noted”. (These findings were not confirmed by other providers.) Motor testing was intact. He diagnosed Brown-Sequard syndrome and recommended a CT myelography, which confirmed there was no change in the anatomy. He confirmed the patient’s complaints to be mid-back pain with radiation mainly into the right lower extremity with associated numbness. Weakness in the left iliopsoas was noted. He recommended surgical intervention via anterior lumbar interbody fusion T11-T12 lateral approach with removal of disc herniation and possible plate screw fusion. A pain diagram (reproduced below) demonstrated no radicular symptoms. By 04/20/11 M.D. noted that she is “not overly complaining of pain” and her examination was normal. Dr. is also the only practitioner to note the presence of “The patient also continues to describe urinary incontinence without fecal incontinence”.

In denying the precertification request, the URA noted” In order for a patient to be a good candidate for spine surgery, the symptoms, imaging and physical examination need to correlate. The patient has a CT/Myelogram dated 03/28/11 revealing a large left paracentral protrusion at T11-T12 producing mild central stenosis, the neural foramina are not significantly narrowed and there is narrowing of the lateral recess. The consistent symptoms are low back and right leg pain (opposite side from the protrusion).”

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

Based upon the ODG and clinical criteria, the proposed surgery is neither reasonable nor necessary. The ODG and best medical practices require that the clinical findings correlate with the imaging studies. Only the requesting surgeon has documented any abnormal findings, which do not correlate with the radiographic studies. There is no



clinical indication for surgery. The patient is neurologically stable. Further, the records do not reflect that there will be a significant improvement in function after the proposed surgery. The records do not reflect appropriate psychiatric/psychological clearance in this patient with known psychiatric illness.

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)**
- AMA GUIDES 5TH EDITION**