

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar posterior interbody fusion with laminectomy discectomy, with single interspace lumbar, posterior non-segmental instrumentation pedicle, facet screw fixation, laminectomy/fasciectomy/foraminotomy 1 segment; lumbar laminectomy/fasciectomy/foraminotomy additional segment; outpatient/inpatient and levels unspecified in request.

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 1982 and is licensed in Texas, Oklahoma, Tennessee and California.

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.

I agree with the recommendation. The recommendation from this reviewer is to uphold the prior two reviewers' recommendation as the medical records do not support the requested procedure: (1) Exact documentation of what procedure and at what levels is not noted; (2) the medical records do not document findings that would support a lumbar fusion at multilevels, as there is not instability documented; and (3) there is not a psychological clearance documented. This review is in line with ODG criteria, low back chapter on lumbar fusion

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 20 page fax 1/18/11 Texas Department of Insurance IRO request, 38 page fax 1/19/11 URA response to disputed services including administrative and medical records

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured xx/xx/xx when he fell from a and hit his head. The patient was unresponsive and was taken to Hospital and subsequently released. The patient has treated with multiple physicians for neck and back complaints.

The patient has seen Dr. for pain management with the request that electrodiagnostic study by Dr. be performed on 11/10/10 by Dr., who noted mild right L5 and/or S1 neurapraxic radiculopathy, mild left S1 neurapraxic radiculopathy, and mild right peroneal motor mononeuropathy.

Subsequently, on 11/17/10, Dr. noted the physical examination having no changes from his original exam, which did note limited range of motion flexion/extension secondary to pain of the lumbar spine with side bending and rotation causing facet loading producing pain. There was right SI tenderness. No focal neurological deficits were noted by Dr.. The 11/17/10 note recommended an epidural steroid injection.

On 12/10/10, the patient was seen by Dr. (it appears to say on the handwritten note) with Dr. exam noting no focal neurological deficits. The patient did have difficulty with all lower extremity stretching activities

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

I agree with the recommendation. The recommendation from this reviewer is to uphold the prior two reviewers' recommendation as the medical records do not support the requested procedure: (1) Exact documentation of what procedure and at what levels is not noted; (2) the medical records do not document findings that would support a lumbar fusion at multilevels, as there is not instability documented; and (3) there is not a psychological clearance documented. This review is in line with *ODG* criteria, low back chapter on lumbar 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)