

Notice of Independent Review Decision

**DATE OF REVIEW:** 07/05/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

L4-5 Decompression x 1 day LOS (63047 & 95920)

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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.

It is determined that the L4-5 Decompression x 1 day LOS (63047 & 95920) is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 06/22/11

- Notification letter from – 05/02/11, 05/31/11
- Report of medical record review by Dr. – 04/12/11
- Surgery Scheduling Slip/Checklist – 04/21/11
- Back Institute Patient Profile – no date
- Follow up office notes by Dr. – 10/07/10 to 04/21/11
- Operative Report for caudal epidural steroid injections by Dr. – 04/01/11
- Report of Electrodiagnostic Study from Institute – 01/24/11
- Consultation by Dr. – 11/20/08, 09/03/10
- Report of MRI of the lumbar spine – 09/33/10
- Report of x-rays of cervical spine post anterior cervical fusion – 07/15/09
- Report of CT scan of the cervical spine – 11/18/08
- Report of cervical myelogram – 11/18/08
- Report of MRI of the lumbar spine – 03/24/08
- Report of MRI of the cervical spine – 11/29/07
- Report of MRI of the thoracic spine – 03/16/07
- Operative Report for anterior cervical fusion by Dr. – 07/15/09
- Consultation by Dr. – 07/09/09
- Operative Note for nerve root block by Dr. – 01/04/08, 03/28/08
- Notes from – 11/23/07 to 11/28/07
- Appeal Review by Dr. – 05/31/11

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when, while working as a, picked up a paraplegic passenger. This resulted in pain to the neck and bilateral arm. He underwent a cervical fusion at C4-5, C5-6 and C6-7. He was able to return to full time work but subsequently developed low back pain and left leg pain. An MRI revealed mild degenerative facet hypertrophy and mild central lumbar stenosis at the L4-L5 level and EMG/NG studies revealed only paraspinal musculature denervation potentials. He has been treated with medications, epidural steroid injections and spinal nerve root blocks. There is a request for the patient to undergo L4-5 Decompression x 1 day LOS (63047 & 95920).

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

The documentation indicates that this patient suffers lumbar radiculopathy as a result of mild lumbar central stenosis and facet hypertrophy at L4-L5 level. The ODG, 2011, low back chapter states "...in patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated non-operatively, and the results in both groups were stable between 2 and 4 years...". The patient has been evaluated and treated non-operatively

for more than 9 months. The medical necessity for this surgical procedure has been established.

**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)