

Notice of Independent Review Decision

DATE OF REVIEW: 07/19/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient laminectomy/discectomy, L4/L5 with one day length of stay

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment forms
2. Letters of denial, 05/09/11 and 05/17/11 including criteria used in the denial
3. Initial evaluation, 02/14/11
4. Initial assessment and radiology reports, 02/04/11
5. Consultation, 04/21/11
6. Forensic Associates forms
7. Emergency room records, Medical Center, 02/14/11

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who suffered an injury to his lumbar spine. The patient was lifting heavy pipe and suffered lumbar strain injury with radiation initially into both lower extremities and then subsequently more into the right lower extremity. The examinee has a recent diagnosis of diabetes mellitus. He has complaints of difficulty completing urination and some bowel incontinence. His physical examination reveals some weakness in the dorsiflexors of the great toe. He has a positive straight leg raising test on the right side, negative on the left side. He has weakness of the extensor hallucis longus. Sensation is diminished in the L5 dermatome. He has palpable tenderness in the lumbar spine region. Imaging studies including an MRI scan have suggested extruded disc herniation on the right side at L4/L5. However, the interpretation of the MRI scan is not as definitive as is reported in the consultation of 04/21/11. There is no EMG/nerve conduction study. Treatment, it would appear, has been primarily with medication and activity modifications. There is no documentation of physical therapy. There is no documentation of epidural steroid injection. There is no documentation of psychological evaluation. The request to preauthorize laminectomy/discectomy at L4/L5 with a one-day hospital length of stay has been considered and denied, and reconsidered and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

There are inconsistencies in this patient's clinical documentation. There is no documentation of definitive findings suggestive of L5 nerve root compressive lesion. The patient is a recently diagnosed diabetic, and this has not been documented as fully evaluated. There is a lack of definitive diagnosis of the source of the patient's lumbar pain and right leg pain. There is no EMG/nerve conduction study. Psychological evaluation is not documented. There is no documentation of treatment other than the use of nonsteroidal anti-inflammatory medication and pain medication. The patient's complaints of urinary frequency are suggested by inability to completely empty his urinary bladder. He has complaints of fecal incontinence on a periodic basis. These symptoms have not been evaluated. The evaluation is incomplete, and the recommendation and request to preauthorize laminectomy/discectomy at L4/L5 was denied. The denial of this recommendation was appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THIS DECISION:

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPH-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 judgment, clinical experience and expertise in accordance with accepted medical standards.

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- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)