

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 10/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar laminectomy/foraminotomy left L3-4, L4-5

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 outpatient lumbar laminectomy/foraminotomy left L3-4, L4-5 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/26/11
- Notice of utilization review findings from – 12/22/10, 01/18/10, 03/08/11, 04/18/11, 04/25/11, 09/12/11, 09/21/11
- Surgery Reservation Sheet from Orthopedics – 09/06/11
- Orthopedic Report by Dr. – 01/13/11 to 08/23/11

- Orthopedic Consultation – 12/06/10
- Report of manual muscle testing range of motion – 12/06/11, 02/15/11, 03/25/11, 04/08/11
- Report of lumbar CT myelogram – 03/28/11
- Operative report for myelogram by Dr. – 03/28/11
- Electro-Diagnostic Interpretation – 12/30/10
- Report of post myelogram CT of the lumbar spine – 03/17/06, 04/22/08
- Report of CT of the lumbar spine – 04/21/05, 03/17/06
- Report of x-rays of the lumbar spine – 01/12/98, 09/23/98, 01/12/99, 08/11/99, 10/11/99, 10/19/99, 02/11/00, 05/23/00, 06/13/01, 10/29/02, 07/28/04, 03/16/05
- Report of x-rays of the chest and lumbar spine – 02/21/02
- Report of lumbar myelogram and post myelogram CT – 11/06/01
- Report of CT scan of the lumbar spine with reconstruction – 08/09/01
- Operative report for lumbar discectomy and fusion by Dr. – 10/20/08
- Operative report for myelogram by Dr. – 04/22/08
- Operative report for ESI by Dr. – 04/20/07
- Operative report for nerve root sleeve block by Dr. – 01/14/03
- Report of lumbar epidurogram – 01/14/03
- Report of lumbar facet injection and blocks treatment by Dr. – 03/07/02, 03/26/02
- Microsurgical Anular Reconstruction (Anuloplasty) following Lumbar Microdiscectomy Chapter 11
- Repair of the Anulus Fibrosus (Anuloplasty) After Lumbar Discectomy Chapter 15.
- Letter from Dr. to – 06/27/11
- Letter from to Dr. – 06/22/11
- Letter from Dr. to Chief Clerk of Proceedings at – 05/18/11
- Notice of Independent Review Decision from The – 05/17/11
- Follow up office visit to Dr. – 03/02/06 to 02/09/10
- Discharge note for physical therapy – 01/19/09
- Prescription for physical therapy – 01/23/09
- Progress notes for physical therapy – 11/10/08 to 01/21/09
- Office visit notes by Dr. – 03/28/06 to 10/28/08
- Consultation by Dr. – 10/15/08
- History and Physical by Dr. – 08/10/07
- Pre-surgical clearance by Dr. – 08/09/07
- Letter of medical necessity for by Dr. – 03/24/07
- Consultation by Dr. – 03/23/07
- Independent medical review by Dr. – 08/16/06
- Office visit notes by Dr. – 01/12/98 to 03/16/05
- Procedure note for spinal injections by Dr. – 04/20/07

- Invasive pain management consultation by Dr.– 08/18/98, 07/16/01
- Pain management consultation by Dr.– 08/21/00
- Examination by unknown physician at Orthopaedic & Spine Assoc. – 02/03/00
- Physical therapy discharge summary – 01/06/00
- PT reevaluation – 05/11/98, 12/02/99
- Notice of Intent to Issue an Adverse Determination from– 01/15/10, 12/21/10, 01/21/11, 04/15/11, 04/22/11, 09/20/11
- Electro-Diagnostic Interpretation – 12/30/10
- Initial functional capacity evaluation – 01/27/10
- Report of functional capacity evaluation 12/06/07
- Report of MRI of the lumbar spine – 09/12/06
- Office visit notes by Dr.– 07/13/06
- Operative report for myelogram by Dr. – 11/06/01
- Report of CT of the abdomen – 12/13/00

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he slipped due to water on the floor. This resulted in an injury to his lower back. He has been treated with physical therapy, medications, spinal blocks with ESI and surgery. The patient continues to complaint of constant lower back pain and the treating orthopedic surgeon is recommending a lumbar laminectomy/foraminotomy left L3-4, L4-5.

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

Based on the medical record documentation this patient is suffering from foraminal stenosis as documented by CT myelogram. The documentation indicates that he has exhausted all of his non-surgical options and surgery is a reasonable option. Therefore, it is determined that the outpatient lumbar laminectomy/foraminotomy left L3-4, L4-5 is medically necessary to treat this patient's condition.

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)