

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 02/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy with fusion and instrumentation L3-4 with bone growth stimulator (BGS) and one (1) day length of stay (LOS).

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 neurosurgery 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 inpatient lumbar laminectomy with fusion and instrumentation L3-4 with bone growth stimulator (BGS) and one (1) day length of stay (LOS) are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 02/02/12
- Notice of Utilization Review Findings – 01/13/12, 01/23/12
- Preauthorization request from Dr. – 01/10/12
- Report of lumbar myelogram – 12/09/10, 12/27/11
- Report of post myelogram CT – 12/09/10, 12/27/11
- Letter from Dr. to Dr. with office notes – 11/04/10 to 01/05/12
- Discharge Summary from by Dr. – 01/18/11
- Operative report by Dr. – 12/08/10, 01/18/11, 12/27/11
- History and Physical by Dr. – 01/18/11
- Report of CT scan of the lumbar spine – 12/09/10
- Appeal of Preauthorization request from Dr. – 01/16/12
- Notice of Intent To Issue An Adverse Determination from – 01/20/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was restraining a patient and suffered an onset of low back pain and leg pain. The patient has undergone three surgeries that included root compression, fusion and instrumentation. There is a request for a lumbar laminectomy with fusion and instrumentation at L3-4 with a bone growth stimulator (BGS).

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

This patient has chronic lumbar mechanical pain and has undergone two myelograms in consecutive Decembers (2010 and 2011) both of which show “stenosis” or “moderate stenosis” at L3/4. The medical record documentation does not provide significant evidence that decompression and fusion at this level will satisfactorily address the patient’s symptoms. In addition, the most recent study indicates a bulging disc with some neural foramen encroachment at L2/3. This makes this level vulnerable to the additional stress imparted by a fusion at the adjacent L3/4 level. This potentially subjects the patient to the necessity for additional surgery in the future. There is mention made of a dorsal column stimulator trial. This may be a more suitable and effective treatment option in this clinical setting, however, the requested procedure as requested is not medically indicated.

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)