

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** October 24, 2012

**IRO CASE #:**

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

Outpatient lumbar laminectomy at L4, L5 and S1 with posterior interbody fusion.

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

M.D., Board Certified in Orthopedic Surgery.

**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)

The requested outpatient lumbar laminectomy at L4, L5 and S1 with posterior interbody fusion is not medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 10/2/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/4/12.
3. Notice of Assignment of Independent Review Organization dated 10/4/12.
4. Employee's Report of Injury dated 7/30/12.
5. Notice of Disputed Issue(s) and Refusal to Pay Benefits dated 9/11/12.
6. radiology reports dated 8/28/12.

7. Emergency Report dated 8/2/12.
8. Employee Injury Treatment Report dated 8/6/12.
9. dated 8/9/12.
10. Physician Order.
11. Durable Medical Equipment Order.
12. office visit notes dated 9/18/12, 8/30/12, 8/23/12, 8/16/12, 8/9/12, 6/28/12, and 6/9/12.
13. Imaging Report dated 8/28/12.
14. Denial documentation dated 9/28/12 and 9/19/12.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who reportedly sustained an injury to the lower back on xx/xx/xx. A magnetic resonance imaging (MRI) of the lumbar spine dated 8/28/12 demonstrated disc degeneration at L4-5 and L5-S1; superimposed large 1cm left paracentral disc extrusion at L4-5 markedly compressing the thecal sac and the left L5 root sleeve. Also noted was relative severe central canal stenosis; mild bilateral facet degeneration; and 8mm left paracentral slightly superiorly directed disc extrusion at L5-S1 mildly effacing the anterior thecal sac and the proximal left S1 root sleeve without impaction; mild relative central stenosis; and mild bilateral facet degeneration. The patient has requested authorization and coverage for outpatient lumbar laminectomy at L4, L5 and S1 with posterior interbody fusion.

The URA indicates that the requested services are not medically necessary for treatment of the patient's medical condition. The URA states that the patient has had minimal conservative care, no evidence of instability, correlation of findings with MRI, psychological screening, and no neurologic exam abnormality.

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

The Official Disability Guidelines (ODG) criteria and community treatment standard require at least six months of conservative care prior to considering spinal fusion in the absence of signs or symptoms suggestive of a progressive neurological deficit. Such signs and symptoms include bowel and bladder dysfunction, or evidence of instability. The ODG further requires identification of pain generator as demonstrated through testing such as discography. This patient's records do not document six months of conservative care since her injury on xx/xx/xx. In addition, there is inadequate identification of the patient's pain generator. Thus, in the absence of a progressive weakness demonstrating a neurological deficit, the requested surgical intervention is not medically necessary for treatment of this patient's medical condition.

Therefore, I have determined the requested outpatient lumbar laminectomy at L4, L5 and S1 with posterior interbody fusion is not medically necessary for treatment of the patient's medical condition.

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**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 JUDGMENT, 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)**