

The DYLL REVIEW

We take the worry out of Peer Reviews

25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

Notice of Independent Review Decision

November 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Surgery to redo right sided lumbar decompression at L5-S1 with Discectomy between 10/2/13 and 11/16/13; 1 assistant surgeon between 10/2/13 and 12/1/13; 2 days of in-patient stay between 10/2/13 and 12/1/13; 1 pre-op lab testing to include, CBC, CMP, PT, PTT, bleeding time, ESR, UA, PA CXR, XR AP/LAT lumbar spine between /2/13 and 12/1/13.

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

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 medical necessity exists for each of the health care services in dispute.

Upon independent review, the physician finds that the previous adverse determination should be overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 18 page fax 11/05/13 Department of Insurance IRO request, 631 pages received via UPS 11/11/13 URA response to disputed services including administrative and medical. 07 pages received via Fax 11/14/13 Provider response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 11/05/13.

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PATIENT CLINICAL HISTORY [SUMMARY]:

This male has a prior history of laminectomy/discectomy. The patient is status post right-sided L5-S1 decompression and currently has seen for a flare-up of right leg pain. The patient has a current MRI noting the large recurrent right-sided disk herniation at L5-S1 compressing the S1 nerve root, and currently has noted physical examination findings of plantar flexion weakness at 3/5 and an absent right ankle jerk with decreased sensation in the posterior calf and posterolateral right foot, all of which correlate with the MRI. The patient has been treated through pain management with pain medication, nonsteroidal anti-inflammatory medication, injections, and clearly indicated the patient's prior physical therapy postoperatively had the patient well trained in exercises, and currently the patient continued to do those exercises without benefit.

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

The patient currently has radicular right leg pain, has positive physical examination findings with the decreased sensation, the myotomal weakness, and the Achilles reflex all correlating with the large right-sided L5-S1 disk herniation compressing the S1 nerve root, and the patient has failed appropriate conservative treatment. This recommendation is in line with ODG criteria for laminectomy/discectomy.

1. The 09/16/13 report did note the patient was a candidate for surgical treatment, and the subsequent 10/28/13 review again recommended noncertification of the request noting the patient's prior physical therapy had been in 2009 and 2010 following the previous lumbar surgery, and currently, without physical therapy, the discectomy was not medically necessary. The 10/15/13 rebuttal letter indicates the patient had been with pain management with treatment including various pain medications, various nonsteroidal anti-inflammatory medications, and injections with continuing to do exercises and stretching. It was noted the patient previously in therapy was well-versed in the physical therapy exercise regimen and now had continued with exercising and stretching. With that noted, the recommendations to overturn the prior review as the patient has documented appropriate rehabilitation 10/15/13 report.

With the surgical procedure necessary, the assistant surgeon is medically indicated within CMS recommendations indicating assistant surgeon is appropriate for a lumbar discectomy. The two-day inpatient stay is medically necessary within ODG recommendations for up to 2.5 days. The CBC is medically indicated within ODG recommendations, as a laminectomy has significant bleeding, and therefore, the CBC would be medically necessary. The urinalysis is not medically necessary, as the patient is not having a planned foreign material implanted at the time of surgery. The coagulation studies are not

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indicated, as there is not a history of bleeding or medical conditions predisposing the patient to bleeding or if the patient is taking anticoagulants. The complete metabolic panel is not supported as medically necessary, as the patient did not have documented medical comorbidities supporting a complete metabolic panel and the coagulation studies or the PT, PTT, and bleeding time. The chest x-ray is not supported as necessary, as the patient is not noted to be a smoker, and no pulmonary diseases were identified. The request for x-rays of the lumbar spine with PA and lateral would be indicated for preoperative planning to utilize at the time of surgery for identification of the appropriate level, and the sed rate was not documented as medically necessary, lacking identification of medical issues possibly defined by evaluating for inflammation.

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)