IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 3/31/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One day inpatient length of stay to perform a lumbar laminectomy with fusion and instrumentation L3-4, purchase one thoracolumbosacral back brace.

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

M.D. Board Certified in Orthopedic Surgery Fellowship Trained Spine Surgeon.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	3/11/2013
Notice of Utilization Review Findings	2/13/2013-2/26/2013
Pre-Authorization Request Clinical Notes	2/07/2013 2/07/2011-1/24/2013
History and Physical /Admission report Operative Reports Radiology Report Discharge Summary	3/01/2011 3/01/2011-12/28/2012 6/13/2011 3/04/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

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Injured worker sustained a low back injury in xxxxxx and is s/p lumbar laminectomies and fusion L4-S1 1999, and s/p DCS implant 2002, and revision DCS 2011. Currently injured worker is complaining of progressive low back pain and leg pain. Examination shows loss of lumbar lordosis decreased lumbar range of motion and sensory and myotome involvement of the thighs. A CT myelogram performed 10/2012 showed no spinal stenosis at L3L4, no foraminal stenosis at L3L4, and no significant degenerative disc disease at L3L4. Nonetheless, an L3L4 ESI was performed recently for but was not therapeutic. Due to persistent symptoms the requesting surgeon is recommending lumbar decompression and fusion at L3L4.

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

Per ODG references, the requested one day inpatient to perform lumbar laminectomy with fusion and instrumentation L3-4, purchase one thoracolumbosacral back brace are not medically necessary. There is minimal correlation between the CT myelogram findings and the requested procedure. Based on the diagnostic CT scan, there is no clear evidence of spinal instability, central stenosis, lateral recess stenosis. Or even foraminal stenosis. In addition there does not appear to be any radiographic evidence of adjacent segment degeneration or spondylolisthesis at L3-L4. Given lack of spinal instability, disc degeneration, or spinal stenosis, a fusion and decompression is not 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 KNOWLEDGE BASE
- ☐ 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