

Notice of Independent Review Decision

DATE OF REVIEW: 04/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A lumbar laminectomy at L4, L5, S1 and discectomy at L5-S1 as outpatient

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

The TMF physician reviewer is a board certified neurosurgeon 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 a lumbar laminectomy at L4, L5, S1 and discectomy at L5-S1 as outpatient is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 03/20/13
- Decision letter – 01/25/13, 02/22/13
- Office Visit Notes – 12/13/11 to 03/05/13
- Operative Note – 06/12/12
- Request for Procedure – 12/24/12, 01/21/13, 02/07/13
- Report of Mental Health Assessment – 12/11/12

- Report of MRI of the lumbar spine – 11/29/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx resulting in injury to the lower back. He has been treated with physical therapy and epidural steroid injections. The patient continues to have pain on the left side and left hip that goes down the left thigh and left leg, with numbness to the thigh and left leg, with tingling behind the knee. There is a request for the patient to undergo a lumbar laminectomy at L4, L5, S1 and discectomy at L5-S1 as outpatient.

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

This patient sustained an on the job motor vehicle injury and thereafter developed low back pain and left lumbar radicular symptoms. The injury occurred on xx/xx/xx and the symptoms have not responded to conservative care that included anti-inflammatory medications, muscle relaxing medications and a lumbar epidural steroid injection done on 06/12/2012. Physical examinations have varied from unremarkable to numbness in the left leg. An MRI done on 11/29/2011 shows a 3.5mm central disc protrusion at L5/S1 with patent foramina and small disc osteophytes and a mild bilateral foraminal compromise at L4/5. There is insufficient physical examination and abnormal imaging studies to justify the recommendation for a lumbar laminectomy at L4, L5, S1 and discectomy at L5-S1.

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)