

Notice of Independent Review Decision

DATE OF REVIEW: 02/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L4/L5, L5/S1 discectomy, L4/L5 fusion with TLIF and spinal monitoring with an inpatient stay x5 days.

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 orthopedic surgeon 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 left L4/L5, L5/S1 discectomy, L4/L5 fusion with TLIF and spinal monitoring with an inpatient stay x5 days 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 – 44642
- Notification of Adverse Determination/Partial – 11/08/12
- Notification of Reconsideration Adverse Determination – 01/23/13
- SOAP Notes – 11/01/12

- Report of MRI of the lumbar spine – 04/12/12
- Presurgical Behavioral Health Evaluation – 12/14/12
- Request for Preauthorization – 12/03/12
- Referral – 11/29/12
- Work Comp Pre-Auth Request Form – 11/05/12
- Progress notes – 08/24/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related lumbar injury on xx/xx/xx when he and slipped and fell. He has a past history of laminectomy/discectomy at L4-L5. He was diagnosed with lumbar strain and an MRI on 04/12/12 revealed, in addition to the post surgical changes at L4-L5, a 3mm broad based posterior disc protrusion with right sided L5 nerve root compression. He had significant facet arthropathy at L4-L5 and there was a 3.5mm disc protrusion at L5-S1 with moderate to severe S1 nerve root compression on the left. The patient was complaining of left leg pain and numbness in the left foot. Diminished sensation was reported on the lateral aspect of the left foot and straight leg raising test was positive on the left. He was treated with medications and physical therapy and underwent epidural steroid injections (ESI) without persistent benefit. There is a surgical recommendation for lumbar laminectomy/discectomy at L4-L5 and L5-S1 including TLIF at L4-L5. Psychological evaluation was performed on 12/14/12 and he was cleared for the surgical procedure psychologically.

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

This patient has a past history of lumbar surgery at L4-L5 and x-ray evidence of facet arthropathy at two levels. He had an initial diagnosis of lumbar strain after the fall of 03/23/12. The diagnosis was changed to intervertebral disc displacement after the MRI of 04/12/12 revealed disc protrusions at L4-L5 and L5-S1 with nerve root compressions. Non-operative treatments including activity modification, NSAID and muscle relaxant medication, physical therapy and ESI were provided without benefit. He has history and physical findings suggestive of nerve root compression with confirmation revealed on special imaging studies. Considering that the patient has a past history of surgery at L4-L5 and significant facet arthropathy, the risk of failure to relieve pain with a spinal fusion would be greater than 50%. Under such circumstances, the spinal fusion should be limited and in the absence of demonstration of instability, an adverse determination is respectfully recommended.

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)