



Southwestern Forensic
Associates, Inc.

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE: February 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Fusion of 360°, bilateral laminectomy, and cyst excision

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

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

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 medical necessity per the Official Disability Guidelines has not been demonstrated for the requested surgery.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI Case Referral
2. Progress note dated 04/09/12.
3. MRI of lumbar spine dated 04/12/12.
4. EMG dated 04/18/12.
5. Progress notes dated 05/25/12, 09/28/12, 10/26/12 and 11/30/12.
6. Procedure note dated 08/07/12.
7. Progress note dated 09/05/12.

8. CT myelogram dated 11/12/12.
9. X-ray of lumbar spine dated 11/12/12.
10. Psychological evaluation dated 12/26/12.
11. Handwritten notes dated 09/05/12, 6/26/12 and 09/15/12.
12. EMG/NCV dated 04/18/12.
13. Therapy Progress Notes dated 09/14/12 and 09/17/12.
16. Preauthorization Request dated 01/09/13.
17. Preauthorization Review dated 01/09/13, with attached documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was injured on xx/xx/xx. He has persistent low back and leg pain. There is decreased sensation in the right S1 distribution and motor weakness in the bilateral extensor hallucis muscles. The MRI shows either a root or facet cyst at L5/S1 and a herniation. The CT myelogram shows no impingement and no cyst. Epidural steroid injections were performed. Multiple diagnostic studies were normal. The psychological evaluation was favorable. Physical therapy has also been completed.

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

The Official Disability Guidelines require evidence of instability or neural arch defect for the fusion. The CT myelogram shows no stenosis, no instability, no cysts, and no impingement. The ODG criteria are not met for the requested surgery.

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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)