



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

Notice of Independent Review Decision

DATE OF REVIEW: 1/29/2014

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Laminectomy Discectomy Fusion @ L5-S1, apply spine prosthetic device, autograft, insert spine fixation device, treat spine fracture, reduction of subluxation, removal of tissue for graft allograft. Inpatient hospitalization 2 days.

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
Department of Insurance Notice of Case Assignment	1/09/2014
Utilization Review Outcomes	12/23/2013-1/07/2014
Designated Doctor Evaluation	4/03/2013
Pre- Authorization Request Surgical Consultation MRI report	8/05/2013 9/24/2013 9/25/2013
Evaluation	11/19/2013
Visit Note	9/23/2011
Follow-Up Evaluation	11/14/2011-7/16/2013
Visit Note	9/15/2012
Assessment & Plan,Referral	9/30/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

male involved in an MVA where he was rear-ended and sustained acute low back and leg pain secondary to the injury. Over a period of one year he was treated conservatively to include



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medications, pain management, and by report ESIs and physical therapy. Due to the failure of conservative care he was referred to a spine surgeon. Surgeon gave him the option of continued conservative care versus L5-S1 fusion.

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

Per ODG references, the requested "Lumbar Laminectomy Discectomy Fusion @ L5-S1, apply spine prosthetic device autograft, insert spine fixation device, treat spine fracture, reduction of subluxation, removal of tissue for graft allograft; inpatient hospitalization 2 days" is not medically necessary because there is not enough documentation of physical therapy being performed nor the patient's response to therapy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- 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