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Notice of Independent Review Decision

DATE OF REVIEW: December 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy
Lumbar discectomy
Lumbar fusion at L4-5
Two-day length of stay

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

M.D., Board Certified in Orthopedic Surgery.

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 requested lumbar laminectomy is medically necessary.
The requested lumbar discectomy is medically necessary.
The requested lumbar fusion at L4-5 is not medically necessary
The requested two-day length of stay is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 11/20/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) undated.
3. Notice of Assignment of Independent Review Organization dated 11/25/13.

4. Denial documentation dated 10/1/13 and 11/12/13.
5. Clinic notes dated 9/24/13 and 10/17/13.
6. Clinic notes dated 7/3/13.
7. Clinic notes dated 3/21/13, 6/11/13 and 8/13/13.
8. MRI of the Lumbosacral Spine dated 3/27/12 and 8/6/13.
9. MRI of the Lumbar Spine dated 10/4/11.
10. Mental Health Assessment dated 6/27/13.
11. Functional Capacity Evaluations dated 6/20/13 and 7/1/13.
12. Texas Workers' Compensation Work Status Report dated 10/7/13.
13. Letter dated 5/20/13.
14. Pre-authorization request dated 6/21/13.
15. Functional Capacity Evaluation Authorization and Informed Consent Agreement dated 6/20/13.
16. Request for Work Hardening dated 5/20/13 through 7/5/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work-related injury on xx/xx/xx and reports low back pain. An MRI of the lumbar spine dated 10/4/11 revealed central and left lateral and left central disc herniations and extrusions at L4-5 causing thecal sac compression anteriorly with left lateral recess stenosis and left neural foraminal stenosis, all at the L4-5 level. A subsequent MRI of the lumbosacral spine dated 3/27/12 revealed L4-5 postsurgical changes with a left hemilaminectomy and associated extensive left epidural fibrosis. A left paracentral disc herniation measuring 6mm was seen with neural impingement upon the left exiting nerve root and the left exiting nerve. A mental health assessment on 6/27/13 noted that participation in a work hardening program was highly appropriate and medically necessary for this patient. Clinic notes dated 7/3/13 indicate she continued to report low back pain. On examination she had a sensory exam that revealed deficits in an L4-5, L5-S1 area pattern with paresthesias to the left lower extremity. Straight leg raise was positive on the left at 40 degrees, and 65 degrees on the right. Reflexes were 2+/4 on the left and 2+/4 on the right. An MRI of the lumbosacral spine dated 8/6/13 revealed at L4-5 there was 4-5mm paracentral disc herniation impressing upon the left exiting nerve root. At L3-4 there was a 2mm left disc herniation. On 9/24/13, the patient reported severe left L4-5 radiculopathy with numbness and decreased sensation in an L4-5 distribution with tenderness to the lumbar spine. The patient's provider recommended a laminectomy and discectomy at L4-5 with fusion. The patient returned on 10/17/13 for further evaluation and still reported low back pain and left lower extremity pain constant rated at 10/10. Neurologically she reported severe pain to the left leg with pain rated at 10/10 with decreased feeling sensation at L5 and straight leg raise was 60 degrees.

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

Official Disability Guidelines indicate that a lumbar laminectomy and discectomy may be considered reasonable and necessary for patients who have failed conservative measures and have consistent findings on clinical exam that correlate with imaging studies. In this case, the records indicate the patient has a disc to the left at L4-5 oppressing upon the left exiting nerve

root. She is in severe pain rated at 10/10 and has decreased sensation on last clinical exam and has radicular pain. The patient has had conservative care in the form of a lumbar support and medications, activity modification and still has persistent pain. In addition, the requested two-day length of stay is also supported by Official Disability Guidelines for this requested service. However, the medical records do not indicate significant instability in the lumbar spine or significant facet pathology for which a decompression would produce instability for which a fusion would be required. Therefore, the requested lumbar laminectomy and discectomy and two- day length of stay is considered medically necessary; however the requested fusion at L4-5 is not medically necessary, as there is lack of documentation of significant instability in the lumbar spine or significant facet pathology for which a decompression would create instability, necessitating a fusion.

In accordance with the above, I have determined:

the requested lumbar laminectomy is medically necessary;
the requested lumbar discectomy is medically necessary;
the requested lumbar fusion at L4-5 is not medically necessary;
the requested two-day length of stay is medically necessary.

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 KNOWLEDGBASE
- 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)