

Notice of Independent Review Decision

DATE OF REVIEW: 09/03/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Two (2) day inpatient hospital length of stay (LOS) following L5-S1 mini 360 and decompression

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 two (2) day inpatient hospital length of stay (LOS) following L5-S1 mini 360 and decompression is not medically necessary to treat this patient's condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker is a male who suffered a lumbar straining injury in a slip and near fall on xx/xx/xx. He suffers severe low back pain and left leg pain and sensory deficit. He has been treated in a protocol including activity modification, medications including NSAIDs and chronic pain medication as well as epidural steroid injections. Physical

findings and MRI scan confirm degenerative disc disease at L5-S1 with severe stenosis effecting bilateral S1 nerve roots. The recurrent request is for preauthorization of laminectomy, decompression, discectomy and mini 360 (anterior and posterior fusion).

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

There is no documentation of psychological evaluation and formal documentation of lumbar instability is not present. The criteria as stated in the ODG Indications for Surgery—Discectomy/laminectomy—to allow preauthorization of a lumbar fusion are not documented. Therefore, it is determined that the prior denials of this surgical preauthorization should be upheld.

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)