

IRO REVIEWER REPORT

DATE OF REVIEW: 10/22/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Upper lumbar release osteotomy and instrumented fusion with three day length of stay

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 who is on the TDI-WC approved doctor's list 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 upper lumbar release osteotomy and instrumental fusion with Three day length of stay is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

_Letter from attorneys to Texas Department of Insurance – 10/03/07
Information for requesting review by an IRO – 10/03/07
Decision from Inc. – 09/10/07, 09/25/07

Letter from attorneys– 10/10/07
Report of CT scan of the lumbar spine – 07/11/07
Report of post myelogram CT scan – 03/22/07
Report of xray lumbar myelogram – 03/22/07
Operative report from lumbar myelogram – 03/22/07
Report of lumbar myelogram – 01/11/04
Office notes from Dr.– 12/15/05 to 08/28/07
Letters from the patient – 09/16/07, 10/11/07
Note: The URA/carrier did not provide ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury when he suffered re-injury to his lower back resulting in the need to extend a previous spinal fusion to include L4-L5. The patient has been treated with a previous spinal fusion at L5-S1 and then a Subsequent fusion with instrumentation at spinal level L4-L5. The patient then had Hardware removal in mid 2004. The patient complains of pain the low back above the Area of his prior fusion and is unable to stand erect.

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

The medical record documentation does not substantiate the medical necessity for The performance of a release and spinal osteotomy. The medical record documentation is not clear as to the chief complaint to be treated by the proposed Surgical procedure. It is not clear whether the patient is experiencing back pain, radicular pain, a deformity, or a combination of these symptoms and findings. The record contains no accurate measurements including at what level the angular kyphosis is centered and if there is any contribution to the patient's stance by hip fixed flexion contracture. In addition, the record does not indicate under what circumstances or when the fracture occurred or how it was treated.

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)