

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/18/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360 fusion at L5-S1

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 360 fusion at L5-S1 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 04/03/08
- Decision letter – 02/25/08, 03/14/08
- Institute Preauthorization Request Form – no date
- Behavioral Medicine Evaluation Report – 09/05/07

- Office Visit Notes from Dr. – 07/31/07 to 02/12/08
- Report of MRI of the lumbar spine – 01/03/07, 01/08/08
- Operative report by Dr. – 04/05/07, 05/24/07, 01/31/08
- Radiographic interpretation Note – 04/05/07, 05/24/07, 01/31/08
- Operative report by Dr. – 09/17/07
- Report of fluoroscopy – 09/17/07
- Office Visit Notes from Dr. – 02/05/07 to 12/05/07
- Laboratory testing results – 09/15/07
- Office visit notes, illegible signature – 10/12/07 to 01/11/08
- Medical Clinic Initial Injury Report – 10/05/06
- Electro-diagnostic studies from Medical Clinic – 10/20/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury to the lumbar spine on xx/xx/xx when he was lifting a heavy garbage container. An MRI of the lower spine revealed a herniated disk at L5-S1 and he underwent microdiscectomy on 09/17/07. He returned to work on 12/10/07 and fell suffering a second injury on xx/xx/xx. The patient has been treated with medications, physical therapy, activity modifications, and selective nerve root blocks.

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

The ODG, 2008, Low Back, Chapter Pg. 891 provides guidelines for the performance of spinal fusion for “Workers Compensation Patients” with the diagnosis of degenerative disc disease. The MRI scan performed on 01/18/08 is suggestive of degenerative disc disease and probable foraminal stenosis. The patient is not yet more than 6 months post second injury to the lumbosacral spine. Full effort to obtain relief of symptoms by non-operative means has not occurred. Multi-disciplinary efforts should be applied prior to considering spinal fusion. The medical record documentation offers no evidence of instability and there is no diagnosis of fracture or dislocation as a result of the fall. In addition, there are no progressive neurological deficits documented. Therefore, it is determined that this patient is not a surgical candidate.

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)**