



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 04/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

T12-L2 posterior fusion with pedicle screws and rods, BMP, allograft, and autograft with a three day length of stay

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

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)

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.

T12-L2 posterior fusion with pedicle screws and rods, BMP, allograft, and autograft with a three day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbosacral spine interpreted by, M.D. dated 03/24/06
A procedure note from, M.D. dated 10/06/06
A workers' compensation verification form dated 01/05/07
Evaluations with, M.D. dated 01/19/07, 03/18/08, and 04/23/08
Authorization requests from Dr. dated 01/19/07 and 03/18/08
A letter of approval, according to an unknown source, from, L.V.N. dated 02/01/07
A Decision and Order report from, Hearing Officer for TDI, dated 08/16/07
Generated notes from (no credentials were listed), , R.N., (no credentials were listed), and, R.N. dated 03/19/08, 03/20/08, 03/21/08, 03/24/08, 03/25/08, 03/28/08, 03/31/08, 04/04/08, 04/07/08, and 04/08/08
A letter of denial, according to the ODG, from, M.D. dated 03/24/08
Addendum letters from Dr. dated 03/27/08 and 04/08/08
A letter of denial, according to the ODG, from, D.O. dated 04/07/08
A letter addressed to Dr. from dated 04/15/08
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbosacral spine interpreted by Dr. on 03/24/06 revealed retropulsion of the posterior central L1 vertebra with small disc bulges at T12 through L5. On 10/06/06, Dr. performed a lumbar epidural steroid injection (ESI). On 01/19/07, Dr. recommended a posterior fusion at T12 through L2. On 02/01/07, Ms. wrote a letter of authorization a T12-L2 fusion. On 08/16/07, a Decision and Order report indicated the compensable injury of 11/28/05 extended to include a compression fracture at L1 only. On 03/18/08, Dr. wrote a preauthorization request for the surgery. On 03/24/08, Dr. wrote a letter of denial for the lumbar surgery. On 03/27/08, Dr. wrote a reconsideration request for surgery. On 04/07/08, Dr. wrote a letter of denial for the lumbar surgery.

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

This is an interesting case that does not fit the normal criteria for consideration of fusion for degenerative condition. This individual sustained a remote fracture and did very well. There is no evidence, even though it has been accepted as compensable, that the current condition is the source of the ongoing pain. There is also no evidence that a near posterior fusion, one on the convex side of the fracture, will alleviate the patient's pain. Thirdly, there is no evidence that the patient has been appropriately treated with lesser levels of care.

It is not appropriate to proceed with a T12-L2 posterior fusion with pedicle screws and rods, BMP, allograft, and autograft with a three day length of stay, as the diagnosis has not been confirmed and this is not the appropriate treatment for this condition. Therefore, it is not reasonable or 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 AND KNOWLEDGE BASE
- 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)