MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

Medical Review of Texas

DATE OF REVIEW: **JANUARY 23, 2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Internal fixation L4 to S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD, Board Certified in Neurosurgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

X 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Packet of information from the Texas Department of Insurance including letters of adverse determination.
2. A packet of information from Care including the initial office notes of M.D. dated 10/1/07 and later a somewhat

comprehensive review of the patient's history dated 12/7/07. Also included in this packet are descriptions of hardware injections performed as an outpatient by Dr. dated 11/20/07 as well as Dr.'s evaluation as well as a CT myelogram dated 10/23/07.

3. MRI scan of the lumbar spine dated 7/30/97.
4. Second packet of information which specifically outlines the rationale for the adverse outcome.
5. A large packet of information from the Pain Control, Dr. dated 12/27/07, 11/27/07, 11/20/07, 11/15/07, 11/6/07, 10/31/07, 10/23/07, 10/11/07, 9/7/07, 6/1/07, 3/1/07 all the way back to 12/22/04. Included in this is a lumbar CT scan following a myelogram dated 10/23/07, CT scan of the lumbar scan limited dated 3/13/02. Note this study finds that the fusion appears intact.
6. ODG not provided.

PATIENT CLINICAL HISTORY [SUMMARY]:

Unfortunately, there was no specific indication as to how this gentleman initially injured himself. It is not listed in any of the medical records provided. However, in August of 2001 the patient had a two level 360° fusion at both L4 and L5 with a 60 to 70% reduction in pain for approximately two weeks. He states that he certainly had a neurologic benefit from the surgery in that pre-operatively he was wheel chair bound and post-operatively he could walk. Unfortunately he was left with damaged nerves as the patient describes a constant burning in his feet, which continues today. The records appear to indicate that the patient has been followed extensively essentially for the last three years by Dr.. Most recently he has been seen by who felt that the patient had a painful posterior element and an injection in and around that posterior hardware led to five to six hours of 100% relief of the patient's pain. The previous reviewer was concerned that a previous imaging study had shown that there was lateral recessed stenosis and that the patient's symptoms were in fact related to the compression of the nerves related to an eccentrically placed graft.

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

Again, as has been noted by the previous reviewer, there are no guidelines regarding reviews of painful hardware. This is a fairly controversial and unexplored point and recommendations are made on an individual basis. In this particular situation, this gentleman did indeed have a response to his injections in and around his posterior hardware. If there were lateral recessed stenosis, these injections

would substantially improve the patient's symptoms. However, his latest CT myelogram performed 10/23/07, specifically states that there is no evidence of post-operative stenosis. There is no lateral or cervical canal stenosis at L4 or at L5. Further, there has been a laminectomy performed. In addition, clinically the patient is complaining of low back pain. The burning disasthesias that he has had in his feet date back more than seven years. He has some radicular symptoms on exam based upon Dr.'s multiple descriptors of an L5 radiculopathy but apparently this has been in place for a number of years as well, therefore it is very hard to say that the patient's symptoms are in fact related to ongoing root compromise in the face of a negative CT myelogram and symptoms that have been relatively stable for a number of years. Therefore, in this particular instance, based almost solely on the fact that the patient had complete relief of his pain after an injection of his posterior segmental instrumentation, it is reasonable to effect a removal of that hardware.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X **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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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)**