

Notice of Independent Review Decision
PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 6/30/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Posterior Spinal Fusion, Iliac bone crest graft (IBCG), pedicle screws and rods, Aesculap (TLIF) device
2. Inpatient stay
3. LSO brace
4. Cryo unit x 10 day rental
5. Bone growth stimulator

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 2006 and pain Management since 2006.

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

1. Posterior Spinal Fusion, Iliac bone crest graft (IBCG), pedicle screws and rods, Aesculap (TLIF) device Upheld
2. Inpatient stay Upheld
3. LSO brace Upheld
4. Cryo unit x 10 day rental Upheld
5. Bone growth stimulator Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This xx year old male sustained an injury to his low back while at work in xx/xx/xx. He has undergone conservative treatment including activity modification, physical therapy, and a series of epidural steroid injections. The injured worker's leg symptoms resolved with the injections but his low back pain continues. There was a slight spondylolisthesis of L5 on S1 per imaging studies but there was no instability/translation on flexion/extension films. At this time, the request for Posterior Spinal Fusion, Iliac bone crest graft (IBCG), pedicle screws and rods, aesculap (TLIF) device, inpatient stay, LSO brace, cryo unit x 10 day rental, and bone growth stimulator is under review for medical necessity.

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

Given the available medical records and referenced guidelines the request for surgery, inpatient stay, and DME is considered not medically necessary. The case involves a xx year old male who was injured on xx/xx/xx lifting a piece of aluminum. The worker developed immediate low back and right leg pain, including other injuries not at issue with this request for services. Work up included lumbar X-rays, lumbar MRI, EMG/NCS, and CT/Discogram which revealed lumbar disc herniation L4/5 with concordant pain findings on MRI and lumbar DDD with significant facet arthrosis at L5/S1. Mild to moderate stenosis noted on CT at L4/5 and L5/S1. In addition, L5/S1 spondylolithesis without dynamic instability on lateral flexion/extension views. EMG/NCS suggested subacute L4 and L5 radiculopathy on the right. Treatments included activity modification with work place restrictions, PT, and 2 epidural steroid injections after which the employee experienced resolution of leg symptoms but continuation of back symptoms. He then underwent an electrodiagnostic functional evaluation with FCE components that demonstrated essentially normal testing other than findings consistent with the employee's age and premorbid status with evidence of chronic myofascial dysfunction predating the date of injury. In addition to the premorbid state, there is lack of documented instability lack of progressive neurological deficit and lack of documentation in the medical record of psychological evaluation. Utilizing the ODG criteria cited below the request for surgery is considered not medically necessary. In the absence of medical necessity for surgery the requests and subsequent denials for hospital stay and DME are summarily 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

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)