

Notice of Independent Review Decision

DATE OF REVIEW: 12/17/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior lumbar interbody fusion with fixation at L4-5 with posterior Gill laminectomy, transverse process fusion from L4 to L5, and decompression bilaterally above the sacralized L5 to S1 segment and purchase of Cybertech TLSO brace

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)

It is determined that the anterior lumbar interbody fusion with fixation at L4-5 with posterior Gill laminectomy, transverse process fusion from L4 to L5, and decompression bilaterally above the sacralized L5 to S1 segment and purchase of Cybertech TLSO brace are not medically necessary to treat this patient's condition.

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

- Notice To Utilization Review Agent of Assignment of IRO – 03/04/08
- Notice of Assignment of IRO – 03/04/08

- Pre-Surgical Behavioral Health Evaluation – 01/10/08
- Chart notes by Dr. – 07/16/07 to 12/04/07
- Operative note for Caudal Epidural Steroid Block – 10/29/07
- Report of Neuro EMG study – 06/28/07
- Report of MRI of the lumbar spine – 06/14/07
- Claim notes by insurance carrier – 05/10/07 to 02/28/08
- Request for Preauthorization for Surgery 12/13/07
- Information from TDI requesting review by an IRO – 03/04/08
- Letter of determination – 02/05/08, 02/19/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related injury on xx/xx/xx when he was hit by a forklift and fell forward and to the right. He primarily complains of low back and abdominal pain. An MRI of the lumbar spine revealed evidence of a Grade I spondylolytic spondylolisthesis at L4 on L5 and at least partial sacralization of L5. The patient has been treated with chiropractic treatments, physical therapy and caudal epidural steroid injections.

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

This injured employee has no objective physical findings of compressive neuropathy. The EMG and MRI reveal no evidence of acute fracture of the lumbo-sacral spine. The patient has a diagnosis of spondylolysis of L4-L5 with spondylolisthesis and there is no evidence of sequential instability. The psychological evaluation revealed a moderate risk of poor results from surgery. This patient does not meet criteria for the performance of this surgery. Therefore it is determined that under the current clinical conditions, the requested surgical procedure is not medically necessary and is likely to result in less than satisfactory end point if performed.

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)