

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 03/31/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior discectomy and interbody fusion with interbody fixation L3-4, L4-5 posterior decompression, transverse process fusion with internal fixation L3-L5 and 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)

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 anterior discectomy and interbody fusion with interbody fixation L3-4, L4-5 posterior decompression, transverse process fusion with internal fixation L3-L5 and Cybertech TLSO brace is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Request for Preauthorization for Surgery – 01/06/08
- Chart notes from Dr. – 10/10/07 to 01/23/08
- Psychological evaluation – 11/13/07
- Operative Report for lumbar epidural steroid injections – 05/23/07, 08/15/07
- Report of MRI of the lumbar spine – 02/09/07, 04/25/07
- Report of Nerve Conduction Testing – 01/31/07
- Decision letter from– 01/30/08, 02/12/08
- Progress notes with illegible signature – 01/31/07 to 02/06/08
- Report of x-ray of lumbar spine – 10/04/07
- Operative report for laminectomy and decompression – 03/20/07
- Information from TDE requesting a review by an IRO – 03/19/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was moving heavy equipment with a crew over unstable terrain and experienced pain in his middle back radiating to the right low back and lower extremity. The patient has undergone epidural steroid injections and physical therapy treatments as well as a laminectomy discectomy at L4-L5 performed on 03/20/07.

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

The medical record documentation does not suggest instability at the levels of the proposed fusion. The patient's diagnosis is degenerative disc disease without evidence of instability or compressive neuropathy. ODG 2000 criteria for spinal fusion are not met. Therefore it is determined that the proposed surgical intervention is not medically 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 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)