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Notice of Independent Review Decision

DATE OF REVIEW: 10/24/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior Lumbar Interbody Fusion L5-S1
Back brace using L0631
HHA for wound care daily – 5 days

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

Licensed 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.

Posterior Lumbar Interbody Fusion L5-S1 - Overturned
Back brace using L0631 - Overturned
HHA for wound care daily – 5 days - Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained injuries to her right ankle, right knee, right hip and lower back. She has undergone multiple MRI's and examinations with multiple physicians and was noted to reach MMI on 09/04/07. Her most recent medications include Hydrocodone and Ultram.

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

The posterior lumbar interbody fusion at L5/S1 is medically necessary and reasonable as multiple physicians have documented an unstable L5/S1 grade 2 spondylolisthesis, which meets ODG criteria, and the back brace is reasonable as per ODG Guidelines. While noting that doctors have used the brace historically for lumbar fusions, with the new advent of instrumentation, it may not be necessary, but the continued use is still noted. The home health assistance for daily wound care would not be necessary because ODG web-based guidelines only recommend a once every three days home health evaluation of the wound with wound care until the patient's first return office visit. I also feel this is in line with Medicare guidelines.

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)**
-MEDICARE