

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 09/18/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior lumbar exploration with removal of hardware

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 neurological 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 lumbar exploration with removal of hardware is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter – 09/10/08
- Letter of determination– 08/08/08, 08/27/08
- Request for authorization from– 08/05/08
- Office visit notes from Dr.– 04/27/07 to 07/22/08

- Report of the CT of the lumbar spine – 03/19/08
- Report of operation – 04/09/07
- IRO review by Resolutions for Hardware Injections – 07/29/08
- Copy of Treatment History CPT codes – 04/04/05 to 07/22/08
- Notice to TMF of Case Assignment – 09/09/08
- Information for requesting review by an IRO – 09/08/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury to his lower back on xx/xx/xx. On 04/09/07 the patient underwent a decompressive laminectomy L4, L5; posterior interbody fusion 4-5, S-1 with insertion of interbody fusion devices; segmental stabilization with Dynesys system 3, 4, 5 and sacrum with lateral mass fusion 3 to the sacrum. The patient is complaining of discomfort and the treating physician is recommending that the patient undergo an anterior lumbar exploration with removal of hardware and replace with Syntix cage L3-sacrum.

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

The medical record documentation does not substantiate the medical necessity for the proposed surgery. The office note dated 07/22/08 indicates that the patient “has a solid fusion” and “I don’t believe that explantation is warranted at this time”. Therefore, there is no rationale provided for a proposed procedure to include “anterior” lumbar exploration with removal of hardware.

**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)