ZRC MEDICAL RESOLUTIONS INC

DATE OF REVIEW: 04/28/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:
Spinal surgery, L4-sacrum fusion with hardware.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:
1. ZRC forms
2. TDI referral forms
3. Preauthorization Review Summaries dated 01/09/09 and 03/12/09
4. Requestor records
5. M.D., clinical notes, 09/03/08, with addendum 09/12/08, 10/14/08, 12/31/08, and 02/11/09
6. MRI scan, lumbar spine, 04/24/08
7. CT myelogram, 10/08/08
8. Discogram, 11/14/08
9. EMG/nerve conduction study, 07/22/08
10. URA records
11. Email from M.D., 01/09/09
12. Initial request spinal surgery authorization, 01/06/09 and 03/09/09
13. Patient demographics and surgery scheduling forms
14. Workers' Compensation verification forms
15. Preauthorization M.D. Review, 03/12/09

16. Rehabilitation Psychological Evaluation, 02/20/09
17. Pain Select, 11/14/08
18. ODG criteria for the performance of spine fusion

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
This unfortunate female presents with a date of injury of xx/xx/xx, complaining of low back pain and right leg pain. Apparently the patient suffered a lifting injury. An MRI scan performed several days after injury revealed degenerative disc disease without specific nerve root compressive compromise. CT scan myelogram was performed six months after injury, revealing only mild lateral recess narrowing at the level of L4/L5. A discogram has been performed, revealing evidence of degenerative disc disease at multiple levels. Treatments have included physical therapy, medication, activity modification, and reportedly one epidural steroid injection. EMG performed on 07/22/08 revealed right L5 nerve root radiculopathy. The patient has mild sensory decrease on the medial and dorsal aspects of the right foot. The range of motion of the lumbar spine is limited. Muscle strength is intact in both lower extremities. Straight leg raising test is positive on the right side. Deep tendon reflexes are 2+ and symmetric bilaterally. Lumbar spine films were reported as essentially within normal limits without evidence of malalignment, instability, pars defect, or other significant bony abnormality. A psychological evaluation has been performed, confirming that the patient was stable and could proceed with a surgical procedure from psychological considerations. The request for spinal surgery from L4 to the sacrum fusion with hardware has been requested, denied, reconsidered, and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:
This patient does not meet criteria established in the ODG 2009 Low Back Chapter, Surgery Spine Fusion passage. She is suffering degenerative disc disease on the basis of findings suggested by the discogram. However, there are no elements of neural compromise which would potentially be benefitted by a decompression. There is no demonstrated or documented instability of the spine that would require a spine fusion. The prior denials of this preauthorization surgical request have been appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:
(Check any of the following that were used in the course of your review.)

_____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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)