



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: 8/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an IP Interbody PLIF w/Aspen Clamp x2 days LOS.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of an IP Interbody PLIF w/Aspen Clamp x2 days LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : letter – 8/3/09; ODG – Low Back-Lumbar & Thoracic (Acute & Chronic); Pre-authorization request – 11/29/08 & 7/13/09; denial letter – 7/1/09& 7/20/09; , MD Follow-up – 4/6/09; Peer Review – 5/29/09.

A copy of the ODG was provided by the Carrier for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old male who was injured on xx/xx/xx with a herniated disc. He underwent surgical repair on 4/25/07 including laminectomy and fusion attempt. The fusion was not solid and the patient has had recurrence of pain. Workup reveals recurrent extradural impression at L4-5 with a completely truncated L5 nerve root on the right which is compatible with a recurrent disk herniation.

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

The patient's original surgery was a laminectomy and fusion with Moziak putty and platelet enriched plasma. This is a revision of a failed previous fusion which is one of the patient selection criteria for lumbar spinal fusion.

According to the ODG -Patient Selection Criteria for Lumbar Spinal Fusion: Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. This patient meets the criteria for this procedure; therefore, the requested service is approved.

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)**