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Notice of Independent Review Decision

DATE OF REVIEW: 8/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an L4-5 360 fusion (63047, 63090, 20931, 22842, 22610, 22851, and 22558) and 2 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 and has been practicing for greater than 15 years.

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 agrees with the previous adverse determination regarding the prospective medical necessity of an L4-5 360 fusion (63047, 63090, 20931, 22842, 22610, 22851, and 22558) and 2 days LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Pain Management – Dr.
Group
Back Institute

These records consist of the following (duplicate records are only listed from one source): Records reviewed by Pain Management – Dr. Follow-up Notes – 2/9/09 & 3/12/09.

Records reviewed by Mutual Group: letter – 7/23/09, Denial letter – 6/17/09 & 7/15/09; MRIoA report – 6/16/09 & 7/14/09; Back Institute Pre-authorization request – 6/12/09; MD report – 5/13/09.
Records reviewed by Back Institute: Pre-authorization request – 7/9/09, Surgery Scheduling Slip/Checklist – 5/20/09, Injured Worker Information – 3/17/09, Patient Profile – 3/20/09, Follow-up Notes – 3/30/09-5/20/09, Radiology report – 3/30/09; Associates report – 4/14/09; InSight report – 5/15/09; Pain Institute letter – 4/6/09 & 5/14/09; MD Procedure Note – 5/14/09, Initial History & Physical – 4/6/09; Imaging MRI report – 11/21/08; Surgical Center Operative Report – 1/26/09 & 3/5/09

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who was injured lifting at work on xx/xx/xx. He has undergone physical therapy x 6 months and Lumbar ESIs times two which gave no long term relief. Chiropractic treatment has not helped either. Xrays reveal no fracture, tumor or instability. CT reveals DDD at L5-S1and L4-5 and a bulge at L3-4. The discogram was positive only at L4-5 and was concordant. An MRI reveals L4-5 and L5-S1 DDD and normal finding of L1-2, L2-3 and L3-4.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The reviewer states that the psychological evaluation states scores in patient's range are associated with poor outcome from traditional surgical interventions and suggests continued disability without essential changes in this mind set. The patient's workup does not reveal evidence of neural element compression or spinal instability. Discography is of limited diagnostic value.

The following are the ODG criteria for this procedure: Indications for spinal fusion include: (1) Neural Arch Defect (2) Segmental Instability (objectively demonstrable) (3) Functional Spinal Unit Failure/Instability (4) Revision Surgery for failed previous operation(s) (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc. These criteria are not met; therefore, the procedure is not medically necessary at this time.

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)**