

IRO REVIEWER REPORT

DATE OF REVIEW: 12/03/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Modified anterior/posterior fusion L4-5, posterior interbody fusion with iliac bone graft, PEEK, and instrumentation L5-S1, inpatient los x3 days, assistant, TLSO

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 orthopedic 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 Modified anterior/posterior fusion L4-5, posterior interbody fusion with iliac bone graft, PEEK, and instrumentation L5-S1, inpatient los x3 days, assistant, TLSO are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO
- Letter of determination by – 10/27/09, 11/16/09

- Request for preauthorization by Dr. – 10/22/09
- Office visit notes by Dr. – 02/08/07 to 05/01/09
- HBA note from Centers – 02/27/08 to 11/12/08
- Office visit notes by Dr. – 11/20/07 to 01/25/08
- Report of MRI of the lumbar spine – 10/25/07
- Letter from Dr. – 03/14/08
- Review of Additional Medical Records by Dr. – 11/12/08
- Office visit notes by Dr. – 08/06/08 to 03/25/09
- Office visit notes by Dr. – 09/24/08 to 03/15/09
- Office visit notes by Dr.– 08/27/08
- Office visit notes by Dr. – 04/02/08 to 01/06/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient apparently was involved in a motor vehicle accident where he sustained an injury to his right knee, his neck, and his back. The injury was on xx/xx/xx and he has had intermittent difficulty with his back since that time. The patient at this time has had continued complaints about pain in the low back area. He has been treated with an arthroscopy for his right knee in the past from this accident and apparently has gone onto resolve. He was also treated with a cervical fusion of either C4 or C5 and has pain level of 5/10. The patient has some headaches and difficulty since the time of the accident and is showing no real evidence of change in his status over the last three years. The patient now is three years and nine months post injury and he has been seen intermittently by Dr. who has recommended a fusion of his back at L5-S1 and t L4-L5 with a combined approach both anterior and posterior. This proposed surgery is an anterior posterior fusion at L4-L5 and a posterior interbody fusion with either a bone graft or instrumentation at L5-S1. The patient has been treated, but has difficulty to determine how much real therapy in the treatment he has had. He has had epidural injections times at least three and he has only limited results from the same. The patient has continued difficulty with his back and was recommended by Dr. to have a surgical intervention and a surgery as recommended. The patient has been on chronic medications of Soma, Norco, and Xanax since that time for the last several months. There has been documentation of recent physical therapy in the last year on this gentleman. He did have an evaluation psychologically for this, which said he could psychologically undergo a surgical intervention.

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

This patient had a denial by both Dr. and Dr. for his proposed surgery of discectomy and fusion, not meeting the guidelines of the ODG for radiculopathy and evidence of any atrophy or any evidence of neurologic involvement except for the pain. The treating physician Dr. was visited by Dr. and no additional information was available on 11/16/09. The records were reviewed and ODG guidelines were also reviewed. The patient apparently has continued to have intermittent back pain, which goes between 5 and 9. The patient is on the medication; however, he states the medication is no longer helping out. The patient on physical examination has no real evidence of any radiculopathy. He has negative straight leg raising. No signs of atrophy. His reflexes are equal and he goes to toes without difficulty. The patient therefore is one who has chronic back pain over the last xxxx years and xxx months and has not really shown a lot of improvement. The patient is not meeting guidelines and also not responsive to any of the treatment. The patient at this time is not a candidate for the fusion and decompression and instrumentation as indicated by Dr. He does not meet ODG guidelines and there is no medical necessity for this surgery.

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)