



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
CORRECTED REPORT
 Added reviewer's specialty. Corrected date of injury.

Initial Decision: December 16, 2009
Corrected Decision: December 21, 2009

DATE OF REVIEW: 12/14/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
 Thoracic T10-S1 thoracolumbar fusion, LOS 2-3 days

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
 M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:
 Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial, 10/09/09, 10/30/09, and 11/02/09 including criteria used in the denial
3. Designated Doctor Evaluation, 09/24/09
4. Consultation reports, 10/02/09 and 10/23/09
5. Operative and radiology reports, 09/10/09
6. Consultation reports, 06/09/09 and 08/25/09
7. MRI scan, 04/16/09
8. CT scan, 05/26/09 and 05/27/09
9. Operative and radiology reports, 04/02/09
10. EMG/nerve conduction studies, 03/14/09
11. Radiology report, 01/25/09
12. Operative report, 01/23/09
13. Radiology report, 01/21/09

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14. 2007-2008 records, 10/27/07 through 12/15/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who injured his lumbar spine on xx/xx/xx. He underwent L4/L5 and L5/S1 decompression and fusion on 01/23/09. The patient continued to have pain and progressive stenosis in the lumbar spine, and the patient's surgeon and physician's assistant have recommended fusion from T10 level through S1. Imaging findings on 10/23/09 of the lumbar spine reveal multilevel degenerative changes. Physical examination showed bilateral Hoffman's, cross-adductor reflex, and no clonus. The patient had sensory loss in the lower extremities and extensor hallucis longus weakness bilaterally. Romberg was negative. Lumbar myelogram on 09/10/09 revealed postoperative changes with significant stenosis at L3/L4 and multilevel extradural defects.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The patient is felt to have multilevel degenerative disease and stenosis in the lumbar spine. It would not be reasonable to assume that junctional degeneration has occurred since the fusion in January 2009. It is most likely due to progression of underlying degenerative changes in the lumbar spine which are a disease of life and unrelated to the patient's original work injury. However, the requested thoracosacral fusion from T10 to S1 is in no way justified in the medical records provided. This seems an excessively aggressive fusion level, eliminating all motion in the lumbar and sacral spine, although insufficient documentation of an established non-union at the previously attempted spinal fusion area, and it is probably too early to tell whether or not that is a pseudoarthrosis. Based on the medical records provided, as well as the ODG Guidelines regarding lumbar decompression and fusion, this request does not meet medical necessity.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

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