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**Notice of Independent Review Decision**

AMENDED REPORT 12/15/2009

**DATE OF REVIEW:** 12/15/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include a L4/5 transforaminal interbody fusion and pedicle screw instrumentation, autogenous iliac crest bone graft foraminal stenosis and 3-5 day 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. He has been practicing for greater than 15 years and performs this type of service in his daily practice.

**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 a L4/5 transforaminal interbody fusion and pedicle screw instrumentation, autogenous iliac crest bone graft foraminal stenosis and 3-5 day LOS.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: and MD.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: undated surgery order, 3/17/08 general info

sheet, 3/14/08 workers comp form, 3/17/08 to 9/16/09 office notes by Dr., 3/17/08 patient med history form, 8/17/09 report by MD, 7/31/09 operative report, 8/13/09 letter of clarification from TDI, 7/31/09 CT lumbar spine with post discography report and 10/20/09 TWCC 24.

Records reviewed from Dr. : 11/24/09 psych eval, handwritten notes by Dr. 4/10/08 through 8/20/09, PT plan of care (undated), treatment notes from 3/20/08 to 7/29/08, PT referral 3/17/08, 5/1/08 and 6/12/08, 3/20/08 eval by , 3/5/08 to 10/27/09 progress notes by D. MD, , 10/1/09 report by MD, 2/19/09 to 7/10/09 reports by labs, 3/12/09 report by MD, 3/11/09 rad review, 2/26/09 report by MD, 6/9/08 report by MD, 1/23/09 CT discogram lumbar report, 8/14/08 CT myelogram and overhead myelogram report, 4/10/08 lumbar radiograph report, 2/13/08 lumbar MRI with contrast report, 1/23/09 operative report, 7/31/09 lumbar CT with post discography, 5/9/08 operative report, 8/1/08 letter by Dr., 4/29/08 denial letter, 11/22/02 surgical report and 3/28/07 operative report.

Mr.: 11/30/09 letter and DWC 69 with report by MD of 10/6/09.

We did not receive the ODG Guidelines from Carrier/URA.

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male. He injured his back on xx/xx/xx at work. His workup was complicated by level innumeration irregularities, repeat studies with differing results, and the patient's history of previous L4-5 laminectomy and L5-S1 ALIF less than 1 year prior to index injury. A 2/19/09 urine specimen tested positive for oxycodone not prescribed to the patient. On 8/14/08 post myelogram flexion-extension lumbar spine views were noted as stable by Dr.. Flexion-extension views on 4/10/08 noted no evidence of subluxation. Dr. evaluation on 3/11/09 notes a dominant complaint of left lumbar and left leg to foot pain. A discogram CT on 7/31/09 revealed painful lateral right far lateral disc herniation. A progress note from PA-C/Dr. on 10/27/09 notes that the patient exhibits some signs of malingering.

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

**Pre-Operative Surgical Indications Recommended:** Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. The patient meets the criteria set out by the ODG; therefore, the procedure is medically necessary.

**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)