



514 N. Locust St.
Denton, TX. 76201
Off: (940) 382-4511
Fax: (940) 382-4509
Toll Free: (877) 234-4736

Notice of Independent Review Decision

IRO REVIEWER REPORT – WC NETWORK

DATE OF REVIEW: 02/09/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

IP Anterior/Posterior Interbody Fusion

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

Board Certified in Orthopedic Surgery

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.

IP Anterior/Posterior Interbody Fusion - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Physician Order Sheet, Emergency Room, 03/09/05
- Cervical Spine – Radiographs and Nonenhanced CT, CT Head Without Contrast, Pelvis, and Thoracic and Lumbar Spine, Department of Radiology, Hospitals, 03/09/05
- Final Accident Report
- MRI Lumbar/Cervical/Thoracic Spine With & Without Contrast, M.D., 03/16/05
- Examination Evaluation, D.C., 03/16/05, 04/21/05, 06/17/05, 06/21/05, 06/22/05, 06/27/05, 09/09/05
- Orthopedic Consult, M.D., 04/13/05
- Letter from, D.O. to Dr., 04/28/05
- Peer Review, D.C., 05/13/05
- Examination Evaluation, M.D., 06/17/05, 07/13/05
- Letter from RN to Dr., 07/08/05
- Authorization Notice, Services Corporation, 07/12/05
- Letter from RN to Mr., 09/07/05
- Radiology Report, 2 Views of the Chest, M.D., 11/12/05
- Discharge Summary, M.D., 11/12/05
- Designated Doctor Examination, M.D., 11/15/05
- DWC-69, Dr., 11/15/05
- Examination Evaluation, M.D., 11/21/05
- Examination Evaluation, M.D., 03/11/08, 04/15/08, 06/17/08, 10/20/08, 12/08/08
- CMT and ROM Reports, Diagnostics, 04/15/08, 10/20/08
- Dr. Procedure Orders, 04/22/08, 09/18/08
- Adverse Determination Notice, 04/25/08, 05/12/08, 12/23/08
- Surgery Reservation Sheet, Orthopedics, 05/07/08, 12/15/08
- Authorization After Reconsideration Notice, 05/27/08, 05/29/08
- Enhanced Interpretive Report, PsyD, , EdD, 06/17/08
- Withdrawal Notice, 07/21/08
- Operative Report, Injection & Interpretation of Lumbar Discogram (L3-4, L4-5, L5-S1)/Fluoroscopic Localization of Needle Tip Lumbar Spine, Dr. Berliner, 10/01/08
- Post-Discogram C.T. Scan of the Lumbar Spine, M.D., 10/01/08
- Pre-Surgical Consultation and Behavioral Assessment, MA, QMHP, PhD, LPC-S, QMPH, 11/14/08
- Adverse Determination After Reconsideration Notice, 01/09/09
- Notice of Assignment of IRO, TDI, 01/20/09
- Discography information from Spine, Orthopaedic Knowledge Update
- Referral Slip, Orthopedics (No date)
- Letter from Dr. to RN (No date)
- The ODG Guidelines were provided from the carrier or URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient complained of severe pain in the low back area with radiation to the left leg with numbness and weakness. Multiple MRIs were performed, injections were administered, surgery was performed, and he also underwent physical therapy. His most recent medications were noted to be Lortab, Ibuprofen, and Zanaflex.

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

The rationale for non-certification of this request is the medical records provided do not document information that supports the requested anterior/posterior interbody fusion at L4-S1 in accordance with ODG criteria. The ODG notes a neurological defect as criteria which is not identified; an instability in the lumbar spine, which is not identified; mechanical back pain with spinal unit failure with instability, which is not documented in the medical records other than Dr. stating the patient has mechanical back pain which the positive discography does not prove and it is now known with new studies that positive discograms do not routinely identify a pain generating disc or if there is a disc that has had multiple surgeries, which this is not the case; or if there is an infection or tumor present, which is not the case; or if there is a pseudoarthrosis, which is not the case. Therefore, the medical records do not support this requested procedure.

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)**