



AMENDED July 29, 2009

REVIEWER'S REPORT

DATE OF REVIEW: 07/15/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Transforaminal fusion at L2/L3.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. forms
2. TDI referral forms
3. letters dated 06/26/09 and 07/02/09
4. Denial letters, 04/13/09 and 05/20/09
5. ODG references, low back problems
6. Service Corporation withdrawal notice 06/12/09
7. Fax covers
8. Preauthorization requests
9. Clinical notes, 05/29/09, 05/05/09, and 05/04/09
10. Lumbar myelogram with CT scan, 12/12/08
11. MRI scan, lumbar spine, 12/12/08
12. Operative report, 02/02/09
13. Designated Doctor Evaluation, 06/16/04
14. Authorization notice, 04/13/09
15. Adverse Determination letters, 04/13/09 and 05/20/09

16. Patient demographics

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This unfortunate xx-year-old female suffered a slip-and-fall type injury on xx/xx/xx. She subsequently underwent lumbar spine fusion at L4 through S1 utilizing instrumentation. She suffered a postoperative complication of infection and has undergone five subsequent spine surgeries. Recently she has suffered pain, which has been attributed to the presence of the internal fixation hardware as well as the possibility of instability and subluxation at the level of L2/L3. A local injection along the internal fixation hardware at L4 through S1 resulted in significant pain relief. The request to remove the internal fixation has been approved. The request to perform transforaminal fusion at L2/L3 has not been approved but has been considered, denied, reconsidered, and denied.

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

Though there is radiographic evidence of spondylolisthesis or vertebral subluxation at the level of L2/L3, there is no documented instability at this level. The presence of flexion and extension lateral x-rays has not been provided. There is no specific evidence of instability at this level, and, therefore, the justification for a fusion is not present.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)