

Notice of Independent Review Decision

DATE OF REVIEW: 03/10/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar fusion 22558, 22224, 22845, 22585, 22226
DME E0748

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 neurosurgeon 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 lumbar fusion 22558, 22224, 22845, 22585, 22226 with DME E0748 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 02/27/09
- Decision letter– 01/08/09, 01/16/09
- Report of MRI of the lumbar spine – 03/11/08, 08/12/08, 10/10/08

- Report of MRI of the thoracic/lumbar spine – 07/21/08
- Letter to TDI from Dr. – 08/01/08
- Letter to Dr. – 08/15/08
- Electrodiagnostic study – 08/28/08
- Operative report by Dr. – 09/24/08
- Report of lumbar radiographs – 10/09/08, 11/06/08
- Chart notes by Dr. – 11/06/08 to 12/04/08
- Report of CT scan of the lumbar spine – 11/26/08
- Copy of ODG Integrated Treatment/Disability Duration Guidelines for Low Back Problems – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell from a ladder resulting in injury to the lower back. Radiographic studies have indicated disc protrusion and stenosis at several levels. He has been treated with medications, physical therapy and epidural steroid injections and previous spinal surgery. The treating physician states that the patient is still having worsening pain, incontinence and urinary frequency.

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

This patient underwent extensive decompressive spinal surgery about xx months ago without lasting improvement. Post-operative studies do not show significant instability as to justify a multilevel lumbar fusion. Therefore, it is determined that the Lumbar fusion 22558, 22224, 22845, 22585, 22226 with DME E0748 is not medically indicated at this time.

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)