

Notice of Independent Review Decision

DATE OF REVIEW: 03/23/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4/5 360 fusion, to include CPT codes 63090.62, 22558, 22851, 20931, 22612, 63047, 22842, 20931 and 2 day length of stay.

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

The TMF physician reviewer is a board orthopedic surgery 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 L4/5 360 fusion, to include CPT codes 63090.62, 22558, 22851, 20931, 22612, 63047, 22842, 20931 and 2 day length of stay 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 – 03/12/09
- Decision letter – 02/11/09, 02/16/09

- Office visit notes by Dr. – 06/18/08 to 02/02/09
- Consultation by Dr. – 08/21/08
- Report of MRI of the lumbar spine – 09/02/08
- Report of CT of the lumbar spine – 08/01/08
- Procedure report by Dr. – 10/23/08
- Letter – 03/13/09
- Report of review – 02/10/09
- Patient Profile – 08/07/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was working and injured his back resulting in back pain radiating down his leg. He has been evaluated on a number of occasions with some inconsistencies in the physical findings. Straight leg raises have been positive but no EMG or nerve conduction studies have been documented. Motor and sensory examinations have been most often reported normal. An MRI scan has documented intervertebral disc bulges without herniation at L4-L5. Neural compression has not been documented and epidural steroid injections have not been beneficial. There is no psychological evaluation documented.

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

The ODG, 2009, Low Back Chapter, spinal fusion passage is the criteria recommended to be used to justify the performance of spinal fusion. Multiple such criteria have not been met and are not documented in the medical record. The extent and effect of non-operative treatment has not been documented. There is no documentation to suggest compressive compromise of neural elements. There is no documentation to suggest that instability of any motion element of the lumbar spine is present. There is no psychological evaluation. The medical necessity for this surgical procedure has not been established.

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)