

# MEDR X

791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165  
Ph 972-825-7231 Fax 214-230-5816

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/19/09

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a left thoracotomy with repair of interbody pseudarthrosis at T10-T11 via left side thoracotomy with a minimum 3 day LOS (22556, 22851, 32100, & 22840).

### **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. The reviewer performs this type of service in active 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 agrees with the previous adverse determination regarding all services under review.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from Solutions, Inc.: Denial letter – 10/5/09 & 10/16/09; MD Denial letter – 8/25/09, Medical Record Review report – 11/17/06; MD Chart Notes – 4/23/08-6/10/09; MD

letter – 1/20/06 & 8/7/08; MD Office Visit Notes – 6/5/08, Operative Report – 8/28/03; MD CT Scan report – 7/30/03, 2/26/07, & 5/12/08, MRI report – 6/20/03, 2/20/04, 7/12/07, & 7/13/07; MD CT report – 6/6/07; MD MRI report – 10/27/06; MD report – 6/2/06; MD CT Myelogram reports – 3/31/04; MD Operative Report – 9/30/03; MD Operative Report – 9/30/03. Records reviewed from MD: Denial Cover Letter – 10/5/09 & 10/16/09; Spine Care Pre-authorization request – 9/30/09; MD Chart Note – 8/26/09-9/23/09; Bone Scan Report – 7/23/09, MRI report – 4/16/09, CT Scan report – 6/5/09, X-ray Report – 6/5/09. Records reviewed Operative report – 7/24/08 & 1/12/2009, Office Visit Notes – 2/21/06-10/13/09, Progress Note – 4/4/06 & 11/21/06.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a female who sustained an injury to her back lifting a 5 gallon water bottle on xx/xx/xx. PT for 6 weeks provided no relief and she underwent T10-11 fusion by MD in with cages and rib graft. Persistent back pain led to a consultation with Dr on 4/23/08 when no motion was noted on flexion extension thoracic xrays. Dr 's notes repeatedly state on his 5/12/08 review of CT images he believes there is sufficient bone formation to constitute a fusion. A radiologist review of the Thoracic CT of 6/05/09 compared to the exam of 5/12/08 noted no significant change. There is no evidence of cord or exiting nerve compression. Ms was seen for RME by Dr on 1/20/06 and again on 8/7/08 and has been followed by Dr for pain management.

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

Dr repeatedly states T10-11 is fused, changes his diagnosis to pseudarthrosis following SPECT scan. Diagnosis change not corroborated by SPECT scan reading by radiologist. Whether or not pseudarthrosis exists, no nerve root impingement is noted at T10-11. Repeat surgery is not warranted as pain decrease is not expectable at greater than 50% rate. Patient Selection Criteria for Lumbar Spinal Fusion per the ODG: Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature

**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 KNOWLEDGBASE
- 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)