Notice of Independent Review Decision

DATE OF REVIEW: 10/06/09

AMENDED DECISION: 10/07/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior Lumbar Spine Interbody Fusion at L5-S1

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.

Posterior Lumbar Spine Interbody Fusion at L5-S1 – OVERTURNED
Additional Level – OVERTURNED
Laminectomy Lumbar Spine @ L5-S1 - OVERTURNED
Internal Fixation Device – OVERTURNED

Prosthetic Device – OVERTURNED
Allograft – OVERTURNED
In Patient Stay x Three Days – OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Multidisciplinary Report of Consultation, , 08/03/98
- Physician's Orders, , 08/03/98
- Emergency Department Nurses' Notes, , 08/03/98
- Emergency Department Physician Assessment, , 08/03/98
- Nursing Progress Notes, , 08/03/09
- Discharge Planning Summary, , 08/03/98
- Employer's First Report of Injury or Illness, xx/xx/xx
- Clinical Report, , 03/08/09
- Nurse Clinical, , 03/08/09
- Order Sheet, , 03/08/09
- General Instructions. , 03/08/09
- Recheck, , 03/11/09, 03/18/09, 03/28/09, 04/07/09, 04/21/09
- Physical Therapy Continuation Form, , 03/18/09, 03/20/09, 03/23/09
- Physical Therapy Initial Evaluation, , 03/24/09
- Physical Therapy Notes, , 03/24/09, 03/26/09, 03/27/09
- MRI of the Lumbar Spine, , M.D., 04/15/09
- Initial Evaluation, , D.O., 05/12/09
- History & Physical, , M.D., 05/19/09
- Laboratory Results, Laboratories, 05/19/09
- Follow Up Consultation, Dr. , 06/09/09, 06/30/09, 07/16/09, 08/24/09, 09/01/09, 09/10/09
- Operative Report, Dr. , 06/11/09
- Follow Up Note, Dr. , 06/24/09
- Request for Lumbar Surgery, Dr. , 07/08/09, 08/11/09
- Behavioral Evaluation, , M.A., LLC, 08/10/09
- Letter of Medical Necessity, Dr. , 08/14/09
- Denial Letter, , 07/13/09, 08/16/09
- Notice of Disputed Issues and Refusal to Pay Benefits, 09/10/09
- Letter of Medical Necessity, Dr. , Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient incurred a strain to the middle of his back while lifting material. He was treated conservatively with medications, including Vicodin, Flexeril and Medrol Dosepak, as well as with physical therapy. An MRI of the lumbar spine was performed. He underwent a right selective L5 nerve root injection. His most recent medications were noted to be Soma 250 mg 1 three times a day, Naproxen 500 mg twice a day, Hydrocodone 5/500 mg 1 or 2 at bedtime, and Tramadol 50 mg 1 to 2 every six hours.

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

In my medical opinion, the requested posterior lumbar interbody fusion at L5-S1 is medically reasonable and necessary. The patient suffers from low back pain and radicular right leg pain secondary to bilateral pars defects at L5 with a pseudo-disc herniation at this level. In line with the ODG Guideline requirements, this patient has not responded well to conservative management over an extended period of time, over six months at this time, which has included physical therapy and selective spinal injections, as well as a variety of medications which were appropriately prescribed. The patient has also been given psychological clearance. Given the bilateral pars defects at this level, microdiscectomy surgery would not adequately treat this patient. I believe proceeding with a posterior lumbar interbody fusion at the L5-S1 level is not only indicated at this time, but it is the most medically reasonable treatment option.

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)**