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### Notice of Independent Review Decision

**DATE OF REVIEW:** 10/12/2009

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique).

**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. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

**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 disagrees with the previous adverse determination regarding the prospective medical necessity of arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

MD  
Group

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: Office Notes – 4/7/05-7/7/09, Operative

Report – 8/9/05, 4/14/06, 7/20/07, & 12/16/08, Discharge Summary – 9/24/05, 6/29/06, & 7/14/06; MD Radiology report – 8/9/05(x2) & 12/16/08(x2); C. Cox, MD Radiology report – 6/29/07; Health Systems General Diagnostic Report – 2/19/07; MD Radiology report – 4/14/06(x2).

Records reviewed from Group: Denial letter – 6/29/09 & 7/10/09; PRI Reviews – 6/29/09 & 7/10/09; MD Pre-authorization request – 6/24/09, Office Note – 6/17/09 Patient Daily Notes – 1/24/07; Health Systems Computerized Tomography Report – 2/19/07.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker is a male. He was injured during the course and scope of his employment on or about xx/xx/xx. The injury occurred while he and a coworker were lifting an object when he felt lower back pain. His previous surgical history as it relates to this incident is as follows: L5/S1 left laminectomy and fusion in September of 2005 and bilateral laminectomy with fusion and instrumentation in June of 2006. Continued workups since that point of time indicate foraminal and central stenosis at L4/5 and non-union at L5/S1 in the posterior section. His treating doctor notes that continuing neuro-deficit as well as progressing weakness during the last clinical notes. Therefore, the provider is requesting the service that is now under dispute.

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

According to the ODG: Indications for spinal fusion may include: (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.

The patient has progressive neurologic deficit from disc degeneration above level of prior fusion attempt that appears to be a non-union and demonstrable deformity of central and foraminal stenosis causing intractable pain. Therefore, this procedure is medically necessary.

**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)**