

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: August 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-S1 Posterior Decompression and Fusion, L4-S1 Anterior Fusion, Back brace and bone stimulator.

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

AMERICAN BOARD OF ORTHOPEDIC SURGEONS

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

- Request for a Review by an Independent Review Organization, 07/21/10
- Outpatient Diagnostic Center, 11/18/09
- M.D., 12/03/09, 04/21/10
- Pain Medicine, 01/26/10
- Surgery Center, 03/23/10
- M.D., P.A., 05/25/10, 06/07/10, 06/16/10
- Healthcare Systems, 06/01/10
- 06/10/10, 07/27/10
- DWC-69, Report of Medical Evaluation, 06/17/10
- M.D., 06/17/10
- Texas Department of Insurance, 07/27/10

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- Outpatient Diagnostic Center, 11/18/09
- M.D., 12/03/09, 04/21/10, 05/12/10
- Pain Medicine, 01/26/10
- Surgery Center, 03/23/10
- Texas Workers' Compensation Work Status Report, 05/25/10
- M.D., P.A., 05/25/10, 06/16/10, 06/25/10
- DWC-69, Report of Medical Evaluation, 06/17/10
- M.D., 06/17/10

PATIENT CLINICAL HISTORY:

The patient's date of birth is xx/xx/xx. The patient was injured when he was turning a crank, feeling the onset of lower back pain. This then continued to become radicular pain.

An MRI of the lumbar spine on November 18, 2009, indicated the patient had disc bulges at L2-3 with mild facet disease, at L3-4 with moderate disc disease, and at L4-5 with severe facet disease and ligamentum flavum thickening and a synovial cyst. At L5-S1, there was grade II anterolisthesis secondary to pars defect. There was pars hypertrophy, facet arthropathy, canal stenosis, and severe bilateral neuroforaminal stenosis.

The patient was treated with physical therapy, an epidural steroid injection, and was referred to, M.D. Dr. recommended an L4 to sacrum decompression and instrumented fusion, stated due to this substantially arthritic L4-5 facet change in addition to L5-S1. Dr. felt this would make the patient a reasonable candidate to include that level in the fusion. A grade II spondylolisthesis of L5 on S1 also would mandate correction of L4-5, according to Dr. note of May 25, 2010.

The decision has been made by several reviewers that the surgery cannot be authorized due to the lack of specificity of the findings to include L4-5.

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

The patient has very significant lumbar degenerative disease at multiple levels, including L4-5 to a greater degree than L2-3 or L3-4. Dr. is proposing appropriate surgery at L5-S1, i.e. decompression and instrumented fusion. The rationale for including L4-5 is actually fairly clear from Dr. records, i.e. a very significant spondylolisthesis with significant degenerative changes at the level above would mandate inclusion.

I do not uphold the prior decisions to non-certify this surgery. The rationale for the inclusion of L4-5 is appropriate; a grade II spondylolisthesis with severe stenosis at L4-5 would mandate the decompression be extended to L4-5 and to the fusion, as well. Dr. criterion is appropriate, and stated in the medical records. Therefore, I overturn the denial.

Please let me know if any further information is necessary in this regard.

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 (ROTHMANT SIMEONE; THE SPINE CHAPTER ON SPONDYLOLISTHESIS)