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Notice of Independent Review Decision

DATE OF REVIEW: 8/2/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a decompression and TLF at L4/5 and L5/S1, posteriolateral arthrodesis of L4 to S1, pedical fixation at L4 to S1 and a 3 patient inpatient hospital stay.

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 has been practicing for greater than 10 years.

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 a decompression and TLF at L4/5 and L5/S1, posteriolateral arthrodesis of L4 to S1, pedical fixation at L4 to S1 and a 3 patient inpatient hospital stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from: various DWC 73 forms and 4/14/10 report MD.: 6/23/10 denial letter, 7/7/10 denial letter, 5/18/10 and 7/9/10 subsequent med report by Dr., 1/5/10 neurodiagnostic report, 1/8/10 lumbar MRI report, 10/5/09 lumbar radiographic report and a 5/20/10 assessment interview by LPC.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The has had ongoing back pain despite a purported failure of non-operative treatment. L5 radiculopathy has been noted on electrical studies (1/5/10) and an MRI (1/8/10) has revealed disc desiccation at L4-5 and spondylosis at L5-S1. Prior surgical discectomy with left-sided nerve root scarring was noted at L4-5. Disc protrusions were noted at both L4-5 and L5-S1,

with prior discectomy findings at L5-S1 also. Significant neuroforaminal narrowing and nerve root abutment from disc protrusions were noted at L4-5 and L5-S1. Exam findings from the AP have revealed tenderness with decreased spinal motion with positive tension signs bilaterally. Hypoesthesia in the right L5 distribution was noted. Surgical intervention was proposed by the AP.

Denial letters denoted the lack of documentation of the prior operative record and evidence of specific non-op. treatment attempts. The RME from 4/14/10 was reviewed and revealed an opinion non-supportive of fusion on the basis of a lack of instability. AP records were reviewed, including from 7/9/10. The AP reported that instability had been noted on flexion-extension films from 10/5/09. A psychosocial screen from 5/20/10 was also non-problematic. The 10/5/09 dated imaging report revealed "mild transitory instability" of the reducible retrolisthesis of L4-5 and L5-S1 with degenerative discopathy.

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

The claimant has persistent, residual and/or recurrent disc pathology, nerve root impingement and documented instability at the proposed operative levels. The claimant has been vetted via a non-problematic psychosocial screen. The claimant has significant objective findings on clinical exam and imaging studies and has been adequately documented to have failed reduced activities and other non-operative treatments (not atypical for a clinical situation as described within the records.) The AP's considered procedures are reasonably required as per applicable OD Guidelines. Therefore, they are found to be medically necessary at this time.

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)