

Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 12/07/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient, three day stay for exploration of lumbar fusion L4-5 with decompression and extension of fusion L3-S1

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

The TMF physician reviewer is a board certified neurosurgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the Inpatient, three day stay for exploration of lumbar fusion L4-5 with decompression and extension of fusion L3-S1 is not medically indicated to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/23/10
- Decision letter – 10/27/10, 11/18/10
- Established patient notes by Dr. – 05/13/10 to 10/07/10
- Report of CT lumbar spine with myelogram – 06/28/10
- Progress notes from Pain Care – 05/17/10 to 07/13/10
- Report of drug screen – 10/30/09
- Report of x-rays of the lumbar spine – 08/26/10
- Prospective IRO Review Response – 11/24/10
- Request for Authorization – 10/22/10, 11/16/10
- Notes by – 12/02/10 to 11/18/10
- Medical Case Information – 11/15/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in injury to his lower back. The patient subsequently underwent a number of lumbar fusions. Due to complaints of chronic pain, the patient underwent the implantation of an intraspinal pain pump. The patient has had to increase his medication significantly and the patient continues to have low back pain and left lower extremity radicular pain from the L5-S1 distribution. The treating physician indicated that the fusion will need to be extended and has recommended surgical intervention.

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

This patient manifests symptoms and radiographic changes typical of that often seen five years subsequent to a fusion procedure at L4/L5. While it is likely that his symptoms are emanating from L3/L4 and/or L5/S1, the work-up so far does not necessarily support that conclusion. In addition, there is no demonstrated instability at L3/4 or L5/S1. Therefore, it is determined that inpatient, three day stay for exploration of lumbar fusion L4-5 with decompression and extension of fusion L3-S1 are not medically indicated to treat this patient's condition.

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)