

Notice of Independent Review Decision

**DATE OF REVIEW:** 07/06/2010

**IRO CASE #:**

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

L4-L5 transforaminal & posterolateral fusion/5day LOS 22612, 22851, 22840, 20937

**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 orthopedic surgeon 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 L4-L5 transforaminal & posterolateral fusion/5day LOS 22612, 22851, 22840, 20937 is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 06/11/10
- Notification of Adverse Determination– 04/29/10, 06/03/10
- Request for precertification from Dr. – 04/26/10, 05/19/10
- Worker’s Compensation from Orthopaedic – 11/05/08
- Pre-surgical Screening Diagnostic Interview– 04/16/10
- Office visit notes by Dr. – 11/06/08 to 04/23/10
- Report of CT scan of the lumbar spine post myelogram – 01/26/09, 08/11/09
- Report of lumbar myelogram – 01/26/09
- Report of lumbar spine MRI – 10/22/08
- Office notes by Dr.– 01/13/09 to 12/14/09
- Letter from Dr. to Dr. – 03/09/09, 08/11/09
- Procedure report by Dr.– 03/09/09, 08/11/09, 11/17/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was cutting concrete and felt pain to his lower back after lifting the saw. The patient has been treated with medications as well as epidural steroid injections. He has been diagnosed with lower back pain with SI joint sprain and annular sprain of L4-5 disc. The treating physician has recommended that the patient undergo a transforaminal and posteriolateral interbody fusion.

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

A transforaminal lumbar interbody fusion is done from the posterior, proceeding transforaminal in the lumbar area into the disc space where cages are inserted for an interbody fusion. This combined with a posteriolateral fusion across the transverse processes usually utilizing pedicle screws is to immobilize the segment. This is the standard type of lumbar fusion currently being done and is definitely appropriate for someone who has undergone an Intra-discal Electro-thermal Therapy (IDET) of which most have failed.

**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)