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Notice of Independent Review Decision

DATE OF REVIEW: 2/23/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include a 360 mini fusion at L4/5 and L5/S1 with 2 day LOS.

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 15 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 agrees with the previous adverse determination regarding the medical necessity of a 360 mini fusion at L4/5 and L5/S1 with 2 day LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: TX Back Institute (TBI) and Corvel

These records consist of the following (duplicate records are only listed from one source): Records reviewed from TBI: 1/27/10 denial letter, surgery checklist 1/5/10, injured worker info 6/20/08, notes by DO 6/27/08 to 1/5/10, lumbar discogram report 12/22/09, lumbar MRI report 7/22/09, neurodiagnostic report 7/24/09, diagnostic US report 7/24/09, cervical MRI 7/11/07, 7/19/07 lumbar MRI report, left hip MRI 7/11/07, left knee MRI 7/11/07, 4/24/08 procedure note, discharge eval 9/3/08 and initial eval and plan of care form 7/29/08 by PT.

: 1/13/10 denial letter and 1/5/10 note by MD.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This review involves a female who fell at work and was injured. She improved on physical therapy through 7/09 when she fell and has had subsequent lumbar pain. An EMG was normal on 7/24/09 per Dr and, RVN. An MRI reveals normal discs L1/2, L2/3, L3/4 and L4/5. Disc desiccation and 3mm bulge is noted at L5/S1. Discograms reveal positive pain reproduction at L5/S1 and L4/5 with pain at rest after needle insertion

rated as an 8/10. No instability is noted on flexion – extension views per 9/15/09 TBI note.

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

The following are the Patient Selection Criteria for Lumbar Spinal Fusion per the ODG: For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect (2) Segmental Instability (objectively demonstrable) (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. This patient does not meet all of the above criteria; therefore, the procedure is found to not 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 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)