TMF
Health Quality Institute

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Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 11/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-5 & L5-S1, pelvic iliac fixation, Foraminotomy L4-5 & L5-S1, PSF L4 to S1 and spinal monitoring.

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 L4-5 & L5-S1, pelvic iliac fixation, Foraminotomy L4-5 & L5-S1, PSF L4 to S1 and spinal monitoring 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- 11/08/10
- Notice of Denied Utilization Review Determination from – 10/07/10
- Revised Denial Determination on Reconsideration/Appeal from – 10/28/10
- SOPE notes by Dr. – 07/22/10 to 09/23/10
- Letter from Dr. – 09/23/10
- Office visit notes by Dr. – 07/24/08 to 04/20/10
- History and Physical by Dr. – 06/05/08
- Results of lumbar spine xrays – 10/21/10
- Results of lumbar myelogram and CT – 09/20/10
- Results of CT lumbar spine with contrast and myelogram – 04/01/08
- Electro-Diagnostic Interpretation by Dr. – 09/14/07
- Chronic pain evaluation by Dr. – 07/02/08, 07/18/08
- Interim History and Physical by Dr. – 01/23/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was lifting a case of juice resulting in pain to the lower back. The patient had a number of diagnostic studies performed. She had a CT myelogram revealing mild foraminal stenosis at L3-L4 and L4-L5. Facet stenosis was diagnosed at L5/S1. An EMG revealed bilateral S1, left L4 and Left L5 radiculopathy. S1 joint osteoarthritic changes have been described. Physical examination revealed no objective findings of compressive neuropathy of lumbar nerve roots. Diminished sensation was present to the right foot. The patient has been treated with medications, physical therapy and right and left L4-5/L5-S1 lumbar facet injections under fluoroscopy on 01/14/08. The patient continues to complain of lower back pain and the documentation indicates that she has mechanical back pain secondary to facet arthrosis L4-5, L5-S1, EMG evidence of radiculopathy at L4, L5, S1, and failure of physical therapy and injections. The treating orthopedic surgeon is recommending L4-5, L5-S2, TLIF PSF L4-S1 to include fixation with iliac screws due to the S1 joint arthrosis.

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

It would appear that this patient suffers lumbar spondylosis with arthropathy at L4-L5 and L5-S1. A diagnosis of “mechanical low back pain” has been suggested. Symptoms of back pain and lower extremity pain appear to have been worsened by the straining injury of xx/xx/xx. There are no imaging studies that suggested instability at any motion segment. There is a lack of justification for spinal fusion when there is no instability demonstrated. Spinal fusion for

chronic mechanical back pain is not routinely justifiable. Therefore, it is determined that the L4-5 & L5-S1, pelvic iliac fixation, Foraminotomy L4-5 & L5-S1, PSF L4 to S1 and spinal monitoring are not medically indicated.

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)