

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 10/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

5 Day inpatient stay
L3/4 L4/5 TLIF PSF L3-4 Explore L5/S1 Fusion and Spinal Monitoring, multiple
CPT

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:

5 Day inpatient stay
L3/4 L4/5 TLIF PSF L3-4 Explore L5/S1 Fusion and Spinal Monitoring, multiple
CPT is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/30/10
- Notification of Determination from– 09/02/10, 09/21/10
- SOAP notes by Dr. – 07/12/10 to 08/23/10
- Required Medical Examination by Dr. – 06/24/10
- Addendum to Required Medical Examination by Dr. – 08/03/10
- Post Designated Doctor's Required Medical Examination by Dr. – 06/21/10
- Preauthorization Request by Dr. – 08/03/10
- Case Summary Report from– 08/08/10
- Pre-Program Psychological Evaluation by Dr. – 07/16/10
- Telephone Conversation Report by Dr. – 03/19/10
- Report of lumbar facet injections by Dr. – 11/03/10
- Office visit notes by Dr. – 07/13/09 to 04/10/10
- History and Physical by Dr. – 06/01/09 to 11/30/09
- Report of lumbar epidural steroid injection by Dr. – 03/09/10
- Report of lumbar myelogram and CT – 06/09/09
- Report of MRI of the lumbar spine – 05/20/09
- Physical therapy progress notes – 11/13/09 to 11/18/09
- Physical therapy flow sheet – 10/16 to 11/13 (No year)
- Report of Electromyogram/Nerve Conduction Study – 01/05/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he went to pull an and had immediate back and left leg pain. The patient has been treated with medications, physical therapy, lumbar facet injections and epidural steroid injections. He continues to have back and left pain and the treating physician has recommended that the patient undergo L3/4 L4/5 TLIF PSF L3-4 Explore L5/S1 Fusion and Spinal Monitoring, multiple CPT.

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

This patient had previous back surgery in 1983 with a fusion at L5 and S1. He has had previous back and leg pain when he was seeing his primary care physician in 2008. He sustained a work-related injury on xx/xx/xx when he was. This resulted in complaints of back pain and left leg pain. The patient was treated with physical therapy, epidural steroid injections, facet blocks at L4-5, Hydrocodone and Felxeril. The patient has

persistent pain and has undergone multiple studies including CT myelogram and MRI of the lower back. There is evidence of congenital narrow canal, degenerative joint disease with facet joint hypertrophy and degenerative disc disease at L2-3, L3-4 and L5-S1. The patient has a solid fusion at L5-S1. There is no evidence of instability and minimal effacement of the neural structures. With no instability and diffuse bulging of the discs, there is no indication for the fusion. This patient does not meet the ODG guidelines for a fusion.

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)