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**Notice of Independent Review Decision
Notice of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: September 14, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior thoracic interbody fusion at T9-10.

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

M.D., Board Certified in Orthopedic Surgery.

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)

Anterior thoracic interbody fusion at T9-10 is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 8/23/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/24/10.
3. TDI Notice of Assignment of Independent Review Organization dated 8/25/10.
4. TDI Notice to IRO of Case Assignment dated 8/25/10.
5. Letter from dated 8/24/10.
6. Letter from, MD dated 7/26/10.
7. Medical records from Orthopedics dated 7/2/10, 4/29/10, 1/11/10, 11/17/09, 10/12/09, 8/10/09, and 6/22/09.
8. Psychiatric Evaluation dated 6/17/10.
9. Medical records from Diagnostics LLC dated 4/29/10.
10. MRI of thoracic spine dated 9/30/08.
11. Operative Report dated 3/24/09.
12. Denial documentation dated 8/17/10 and 8/8/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an on the job injury on xx/xx/xx. By history, he was running to avoid the path of a falling crane when he turned and looked behind him, injuring his back and neck.

An MRI of the thoracic spine was performed on 9/30/08. The report documented a small T9-10 paracentral disc osteophyte slightly narrowing to the left at the T9-10 lateral recess. No canal stenosis was identified at T6-7 through T9-10. Mild to moderate spondylosis was seen throughout the thoracic spine. Spondylosis was noted as worse from T6-7 through T9-10. A small dorsal lateral disc herniation and osteophyte was seen at T9-10 and slightly narrowed at the left lateral recess. Lateral recesses bilaterally at T6-7 are slightly narrowed secondary to osteophyte formation best seen on the sagittal sequence. No frank central canal stenosis was seen through the AP diameter of the spinal canal. No spinal cord compression or edema was noted.

The patient was seen by his provider in multiple visits. The provider's impression was a T9-10 disc protrusion. The patient has experienced depression and 12 sessions of psychotherapy were planned.

The study of 6/22/09 noted aggravation and degeneration of the lumbar spine with a protrusion of T9-10, left center.

The visit of 8/10/09 discussed epidural steroid injection.

The report of 11/17/09 documented a plan of treatment of psychosocial screening with thoughts about surgery at T9-10. The orthopedic report of 10/12/09 showed an examination revealing mid-thoracic pain and disc protrusion at T9-10 with minimal disc degeneration at L1-2, 2-3, 3-4, and 4-5.

The report of 1/11/10 shows an impression of T9-10 herniated nucleus pulposus with tenderness in the T9 area.

The visit of 4/29/10 shows attempts at psychiatric clearance for surgery and consideration of T9-10 anterior fusion.

On 7/26/10, the patient was given clearance for surgery by a psychiatrist.

The patient's provider recommended anterior thoracic interbody fusion at T9-10. The Carrier has denied coverage for this procedure citing a lack of medical necessity.

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

This patient sustained an injury to his mid-back, however, testing revealed no sign of any bone edema or any new injury in the region of the T9-10 disc space. There are signs of thoracic spondylosis at the T9-10 disc space from T6 to T9. The patient had a physical exam that showed no upper motor neuron findings. Nor is there evidence of weakness, clonus, hyperreflexia or pathology suggestive of an upper motor neuron lesion or a lesion at the level of T9-10. The patient does have back pain and muscle spasm, however, an absolute pain generator has not been identified.

Based upon medical judgment, clinical experience and expertise in accordance with accepted medical standards, the patient's request for anterior thoracic interbody fusion is not medically

necessary. There has been no identification of the pain generator through testing such as discography. This patient does not have any absolute indication for surgery. He has no progressive neurological deficit, no bowel or bladder dysfunction, no perianal paresthesias and no neurological deficit on physical examination or any other type of testing.

The patient has a small disc herniation in the area of the thoracic spine with adjacent degenerative change. A spinal fusion at T9-10 through an anterior thoracic approach is associated with a risk of damage to various structures and could require the take down of the diaphragm, or cause injury to the Adamkiewicz artery as well as other potential issues. Anterior thoracic surgery is reserved for conditions that carry greater potential risks than the corrective surgery itself. Therefore, based upon the screening criteria of medical judgment, clinical experience and expertise in accordance with accepted medical standards, I find the requested procedure is not medically necessary for treatment of the patient's medical 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)