

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

A three day inpatient hospital stay with posterior decompression fusion at L5-S1 at St. David's Hospital as requested by Dr. Fox.

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)

The requested service, a three day inpatient hospital stay with posterior decompression fusion at L5-S1 at St. David's Hospital as requested by Dr. Fox, 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 11/8/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/8/11.
3. Notice of Assignment of Independent Review Organization dated 11/9/11.
4. Medical records from Radiological Association dated 9/15/11 and 10/11/11.
5. Medical records from Urgent Care Center dated 9/6/11, 9/16/11 and 9/22/11.
6. Medical records from MD dated 10/4/11.
7. Case review by MD dated 10/27/11.
8. Texas Workers' Compensation Work Status Reports dated 9/6/11 and 9/22/11.
9. Undated Request for Authorization from MD.
10. Patient Information Report dated 10/6/11.
11. Prospective Review (M2) Response dated 11/11/11.
12. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

Review of the medical records indicates that the patient, a male, injured himself at work on xx/xx/xx and having to bend down. The patient reportedly felt pain in the low back radiating into his leg. An MRI of the lumbar spine was performed on 9/15/11 and evidenced grade 1 anterolisthesis of L5 on S1 with moderate bilateral foraminal stenosis and a small posterior annular tear with minimal disc protrusion at L4-5 without central canal or foraminal stenosis. An x-ray of the lumbosacral spine was performed on 10/11/11, with two views taken, which evidenced grade 1 spondylolisthesis of L5 on S1 without evidence of instability. On 9/22/11 the patient was prescribed tramadol, metaxalone and diclofenac. On 10/4/11 the patient's provider indicated that the patient had developed weakness over the last several weeks and recommended a posterior lumbar decompression fusion at L5-S1; however, the patient's motor strength evaluation on the same visit was graded as a 5 out of 5.

At issue is whether a three day inpatient hospital stay with posterior decompression fusion at L5-S1 at Hospital as requested by Dr. is medically necessary for this patient.

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

The Official Disability Guidelines (ODG), as well as accepted medical standards, require six months of conservative care prior to contemplating a spinal fusion unless there are signs of progressive neurological deficit, bowel and bladder dysfunction, or a potential impending catastrophe due to an instability situation such as a burst fracture or a Quigley Chance fracture.

Additionally, accepted medical standards require identification of a pain generator prior to surgical intervention.

As this patient was injured on xx/xx/xx, he has not yet had six months of conservative care. To date, only three months have passed since the original date of the injury. Therefore, the six month standard has not been met. Although this patient does have a neural arch defect, ODG criteria indicate that spinal fusion is only appropriate in patients with this defect who have failed at least six months of conservative care. Additionally, there is no documentation of an identified pain generator. Further, the patient was not noted to have a progressive neurological deficit. Therefore, I have determined the requested service, a three day inpatient hospital stay with posterior decompression fusion at L5-S1 at Hospital as requested by Dr., 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)