

Notice of Independent Review Decision

DATE OF REVIEW: 05/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar decompression & fusion @ L3-S1 with a 7-day length of stay CPT 63047, 63048 x 2, 22614, 22842, 22851 x 2, 38220, 76001 (26)

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

The TMF physician reviewer is board certified in orthopedic surgery 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 lumbar decompression & fusion @ L3-S1 with a 7-day length of stay CPT 63047, 63048 x 2, 22614, 22842, 22851 x 2, 38220, 76001 (26) are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 05/12/11
- Letter of determination– 03/23/11, 04/13/11, 04/19/11
- Letter to – 05/13/11
- Physician Review Recommendation Prepared – 03/22/11
- PEER Review Report from – 04/14/11
- Worker's Compensation Utilization Review Request – no date
- Clinic Progress Notes from Dr. – 12/03/09 to 11/23/10
- Report of x-rays of the lumbar spine – 09/21/10
- Attorney's appeal of physician review– 04/12/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he fell through a hole in scaffolding to a lower deck resulting in injury to his lower back. He has been diagnosed with spondylosis with prior discectomy. He is experiencing pain to palpation to the lower back with reduced range of motion. Straight leg raising 70 degrees produced pain in the back as well as

tightness in the hamstrings. The patient has been treated with medications and epidural steroid injections. The treating physician has recommended surgical intervention in the form of decompression and fusion at L3-S1 with instrumentation as an option for treatment.

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

This patient has been treated and presently he has no evidence of instability either by MRI or by flexion and extension films. The patient has multilevel diseases and the ODG does not recommend any fusion with more than the two levels involved. The fusion is recommended to go from L3-S1 and therefore it does not fit within these criteria. There is also no evidence of instability. The main treatment on this patient is for pain and it is difficult to treat the patient's pain surgically without any specific orthopedic or neurologic findings. This patient does not meet requirements of the ODG. He has no new information that has been submitted in this case. The recommendation for fusion by the ODG guidelines shows that the patient should not have more than two levels of involvement and must show the evidence of instability. From the criteria for spinal fusion, the chronic low pain problems, fusion should not be considered within 6 months of the symptoms, dislocation or progressive neurologic block. The indication for spinal surgeries included neurologic defect such as spondylolysis or spondylolisthesis, congenital hyperplasia, segmental instability, excessive motion as a degenerative spondylolisthesis, surgically induced segmental instability, mechanically vertebral collapse of the motion of the segment or advanced instability. This patient also has more than two segments involved and therefore he does not meet requirements under the standard guidelines for 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)