

Notice of Independent Review Decision

DATE OF REVIEW: 07/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360 degree lumbar fusion at L4/S1 and right L5/S1 facetectomy with 2-3 day length of stay

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.

Therefore, it is determined that the 360 degree lumbar fusion at L4/S1 and right L5/S1 facetectomy with 2-3 day length of stay 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 – 06/25/12
- Notice of Utilization Review Findings – 05/01/12, 06/08/12
- Preauthorization Request from Dr. – 04/25/12
- History and Physical by Dr. – 09/09/11 to 03/22/12
- Inpatient posting sheet by Dr. – no date
- Post myelogram CT of the lumbar spine – 02/10/12
- Report of lumbar myelogram – 02/10/12
- Report of x-rays of the lumbar spine – 11/09/11, 02/12/11
- Report of MRI of the lumbar spine – 11/22/10

- Procedure Report for epidural steroid injections by Dr. – 10/13/11, 12/08/11
- Follow up office visit by Dr. – 10/04/11 to 05/01/12
- Procedure Report of right S1 joint injection by Dr. – 11/10/11
- Notice of Disputed Issue(s) and Refusal To Pay Benefits – 01/11/11 to 11/02/11
- Report of functional capacity evaluation – 09/22/11, 03/16/12
- Employee's Report of Injury – xx/xx/xx
- Physical Performance Evaluation – 11/03/11, 12/13/11
- Neurophysiological Consultation and Report of Electrodiagnostics by Dr.– 05/12/11
- Emergency Department Record from Hospital – 11/08/10, 11/09/10
- Neurology Consult Report by Dr. – 11/19/10
- Progress Report by Dr. – 11/23/10 to 03/17/11
- Physical Therapy Notes – 11/08/10 to 03/04/11
- Consultation by Dr. – 02/12/11
- Follow up Office Visit Notes by Dr. – 04/06/11
- Progress Notes by Dr. – 06/23/11
- New Patient History and Physical by Dr. – 07/13/11
- Physical Therapy Work Comp Evaluation by – 07/18/11
- History and Physical by Dr. – 08/11/11
- Initial chiropractic evaluation by Dr. – 08/18/11
- Initial Behavioral Medicine Consultation – 08/18/11
- Rehabilitation Progress Notes by Dr. – 09/01/11 to 12/01/11
- Rehabilitation Re-Evaluation by Dr. – 11/14/11
- Consultation by Dr. – 09/06/11
- Follow up Office Visit Notes by Dr. – 09/09/11 to 05/24/12
- Psychological Testing Results – 09/12/11
- Individual Psychotherapy Notes - 09/29/11 to 01/16/12
- Pre-Surgical Psychological Evaluation – 04/03/12
- Medical Record Review by Dr. – 04/07/11
- Report of Medical Evaluation – 05/19/11
- Designated Doctor Evaluation by Dr. – 05/05/11, 10/08/11
- Designated Doctor Evaluation Addendum – 05/19/11
- Report of Maximum Medical Improvement/Impairment – 10/21/11
- Report of Medical Evaluation – 03/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when she was performing typical stocking activities in a stock room. She has persistent low back pain and bilateral leg pin in spite of activity modification, medications, physical therapy and epidural steroid injections. Neurological evaluation has been normal until recently when EHL weakness was demonstrated on 01/26/12. A CT myelogram performed on 02/10/12 revealed HNP at L5-S1 on the right. There is failure of complete segmentation at L4-L5. There is no demonstration of instability at any of the lumbar motion segments. The current request is for preauthorization of anterior and posterior lumbar fusion with instrumentation.

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

There is no indication that instability is present at any lumbar motion segment. Potential pain generator sites have not been investigated. The criteria for lumbar spinal fusion have not been met. There is no documentation of psychological evaluation. Therefore, it is determined that the 360 degree lumbar fusion at L4/S1 and right L5/S1 facetectomy with 2-3 day length of stay is not medically necessary to treat this patient's 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)

