

Notice of Independent Review Decision

DATE OF REVIEW: 07/15/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4/5 LEFT extreme lateral interbody fusion, flipping w/pedicle screws

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 L4/5 LEFT extreme lateral interbody fusion, flipping w/pedicle screws 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 – 06/27/14
- Adverse Determination After Reconsideration Notice – 06/20/14
- Adverse Determination Notice – 06/13/14
- Clinic Notes – 04/22/14 to 06/06/14
- Report of MRI of the lumbar spine – 02/13/14
- Physical Therapy Progress Notes – 06/06/14

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when she missed sitting into her chair falling directly onto her back and buttock. She suffers low back pain and bilateral leg pain. She has been treated with medications, activity modification, physical therapy and a single epidural steroid injection. The epidural steroid injection provided 2 weeks of excellent 100% pain relief. An MRI scan performed on 02/18/14 revealed lumbar spondylosis, facet arthropathy, L4/5 canal stenosis with L5 nerve root impingement. Pain interferes with activities of daily living. Achilles reflexes are absent bilaterally. Plain x-rays of the lumbosacral spine reveal L4/5 spondylolysis, grade 1. No psychological evaluation is documented. The current request is for preauthorization of extreme lateral lumbar interbody fusion utilizing pedicle screws.

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

Extreme lateral interbody fusion is not a recommended procedure. The patient lacks documentation to suggest instability of the lumbar spine. The prior denials of this request to preauthorize extreme lateral lumbar interbody fusion utilizing pedicle screws were appropriate and should be upheld.

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)