IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 3/20/2018

IRO CASE # XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
1 Posterior Lateral Interbody Fusion for the lumbar spine, unspecified inpatient / outpatient between XXXX and XXXX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D. Board Certified in Orthopedic Surgery & Sports Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX who sustained a work injury that resulted in low back and leg pain while XXXX. XXXX has undergone chiropractic treatment, physical therapy, and medical management. XXXX has had transforaminal epidural injections at L4-5 bilaterally on XXXX with 100% relief of leg pain and 50% relief of back pain. Per the clinical note from XXXX continues to have significant low back and leg pain with most of the pain being in the back compared to the legs. XXXX pain was 9/10 on the day of the visit.

XXXX is using an assistive device to get around. On exam, XXXX had tenderness in the lumbar paraspinal area as well as decreased and painful ROM. No deformity noted. Neurologically XXXX was intact. XXXX had negative straight leg tests bilaterally. X-rays of the L-spine and an AP pelvis are reported to be normal. MRI of the L-spine showed a central disc protrusion at L4-5 leading to moderate central stenosis and mild central stenosis and moderate foraminal stenosis at L5-S1 due to some disc protrusion. No documentation of spinal instability is noted on exam or imaging.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Per ODG references the requested "1 Posterior Lateral Interbody Fusion for lumbar spine between XXXX and XXXX" is not medically necessary. The request for posterolateral interbody fusion is not certified as the patient does not meet the ODG criteria for spinal fusion. There is no reported or documented evidence of spinal instability, XXXX has not had prior decompression, and XXXX does not have tumor or spinal deformity.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE KNOWLEDGE BASE

☐ 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