



Notice of Independent Review Decision

**DATE OF REVIEW: 1/31/08**

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for transforaminal lumbar interbody fusion.

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

Texas Licensed Orthopedic Surgeon

**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.

The previously denied request for transforaminal lumbar interbody fusion.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 1/16/08.**
- **Request for a Review by an Independent Review Organization dated 1/11/08.**

- Notice to, Inc. of Case Assignment dated 1/16/08.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 1/16/08.
- Disputed Issue dated 1/17/08.
- Recommendation to Services dated 1/2/08, 12/17/07.
- Orthopedic Report dated 12/6/07, 8/23/07.
- Enhanced Interpretive Report dated 11/29/07.
- Review of Medical History and Physical Exam dated 8/6/07.
- Impairment Rating Report dated 8/6/07.
- Patient Medical Information dated 12/31/07.
- E-Mail dated 12/20/07, 12/19/07, 12/11/07.
- Fax Cover Sheet Comments dated 12/31/07, 12/18/07
- Operative Report dated 6/7/06.
- Lumbar Spine MRI dated 7/25/05.
- Office Visit dated 12/21/05.
- Evaluation Report/Letter dated 8/6/07.
- Quickview (unspecified date).
- Surgery Reservation Sheet (unspecified date).
- Pre-Authorization dated 12/13/07.
- Article (unspecified date).

**No guidelines were provided by the URA for this referral.**

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx years

**Gender:** Female

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Slipped and fell down 5-7 steps.

**Diagnosis:** Lumbar degenerative disc disease with facet hypertrophy.

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

The claimant is a xx year-old female who slipped and fell down five to seven steps on xx/xx/xx, with resultant complaints of low back and bilateral lower extremity pain and numbness. A lumbar MRI evaluation completed on 07/25/05 noted L3-4 small left disc herniation with desiccation; L4-5 disc bulge with desiccation; and mild bilateral facet hypertrophy at both levels with all the findings unchanged from a previous study completed on 12/09/03. Electrodiagnostic studies performed on 12/21/05, were negative for radiculopathy or peripheral neuropathy. The claimant treated with physical therapy, medications and selective nerve root blocks at left L3-4. Physical examination demonstrated lumbar tenderness, spasm and limited motion with global weakness and paresthesias along the left L3 and L4 distributions. A psychiatric evaluation was conducted on 11/29/07, without clear interpretations provided. Dr. felt that there were discrepancies on the psychiatric evaluation. Dr. also noted that the disc herniations at

both levels were pretty far lateral and that decompression would destabilize the claimant's spine enough to require fusion. Recommendation was made for transverse lumbar interbody fusion at L3-4 and L4-5.

The claimant is under the care of a number of different physicians for ongoing back and leg complaints. She has undergone a 12/21/05 electromyogram lower extremity, which was normal, as well as a 07/25/05 MRI of the lumbar spine, documenting degenerative disc changes and bulging with small herniation at multiple levels. Dr. would like to proceed with decompression and subsequent fusion due to the fact he feels he would destabilize her at the time of her surgical intervention.

This reviewer does not see the medical indication for the requested transforaminal lumbar interbody fusion. It is not clear as to how much decompression is going to be needed at the time of disc excision and foraminal clean-out. It also seems that a significant amount of the planning for fusion surgery happens to be due to her pain, and this reviewer is really not sure there was any documentation of structural instability, progressive neurologic deficit, or recurrent disc herniation, which might lead one to believe she would benefit from a fusion. Therefore, this reviewer does not see the indications for this requested medical operative procedure.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back- Fusion
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).