



514 N. Locust  
Denton, TX. 76201  
Off: (940) 239.9049  
Fax: (940) 239.0562

## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/04/08

**IRO CASE #:**

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

Anterior Interbody Fusion L4-L5, Additional Level L5-S1, Retroperitoneal Exposure and Discectomy L4-L5, Additional Level L5-S1, Anterior Interbody Fixation L4-L5, Additional Level L5-S1, Posterior Decompression L4-L5, Additional Level L5-S1, Transverse Process Fusion L4-L5, Additional Level L5-S1, Removal Pedicle Fixation L5-S1 with Replacement L4-S1, Bone Graft, Allograft, Bonen Graft, Autograft in situ, Bone Graft, Autograft, Iliac Crest, Bone Marrow Aspirate, Cybertech TLSO, With Anticipated 2-3 Days Inpatient Length of Stay – Lumbar Spine

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

Board Certified in Orthopedic Surgery

### **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.

Anterior Interbody Fusion L4-L5, Additional Level L5-S1, Retroperitoneal Exposure and Discectomy L4-L5, Additional Level L5-S1, Anterior Interbody Fixation L4-L5, Additional Level L5-S1, Posterior Decompression L4-L5, Additional Level L5-S1, Transverse Process Fusion L4-L5, Additional Level L5-S1, Removal Pedicle Fixation L5-S1 with Replacement L4-S1, Bone Graft, Allograft, Bonen Graft, Autograft in situ, Bone Graft, Autograft, Iliac Crest, Bone Marrow Aspirate, Cybertech TLSO, With Anticipated 2-3 Days Inpatient Length of Stay - Upheld

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient sustained an injury on xx/xx/xx. The area of injury was to the left leg and lower back. The patient suffers from diabetes. He has undergone multiple MRIs, C.T.s, x-rays and discogram and has had multiple lumbar surgeries.

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

Based upon the ODG, the existing guidelines for the performance of surgery in , one must have a clear rationale for surgical intervention. This patient has had multiple surgical procedures, including discectomy, a posterior lumbar interbody fusion, and removal of hardware. The medical documentation states the patient has a nonunion at sometimes and a healed fusion at others. A discogram has been obtained, but in this population, discography is unreliable. This patient has chronic pain and a history of depression and stress. The psychological evaluation is contradictory, stating that the patient is having difficulty coping with his injury and then stating he is a good candidate for spinal surgery. These are, in fact, contradictory.

The patient does not meet the criteria set forth by the ODG for the performance of the surgery. There is a discrepancy in the interpretation of flexion and extension films, discography is unreliable, and an individual with diabetes is a poor candidate for spinal surgery. Also, given that this is a revision surgery, I do not anticipate that the patient would improve significantly.

### **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)