

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** May 30, 2008

**IRO CASE #:**

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

L5-S1 PLIF/Fusion to include CPT Codes 22630, 22840, 22851, 20936, 20930

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

Diplomate, American Board of Orthopaedic 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)

**PATIENT CLINICAL HISTORY:**

The case involves a xx year old male who sustained a lower back injury on xx/xx/xx. The patient was "tightening service" when he pulled down on his left knee, shifted, and injured his back. It made a popping sound.

There is an MRI, dated June 6, 2005, disclosing a small broad based left-sided central disc protrusion at L5-S1. There is also a repeat MRI, dated February 27, 2008, disclosing central spinal stenosis from L3 through L5, as well as a posterior central focal protrusion at L5-S1.

There are notes from Dr. recommending surgery. There are also notes from Dr. indicating that epidural injections were performed at a number of different levels; however, the patient received no benefit from any of the three injections. Dr. as well as Dr. recommended surgery.

The carrier did not certify the request for L5-S1 posterior lumbar interbody fusion. The peer reviewer opined that the request for surgery did not meet ODG Guidelines. He quoted ODG Guidelines that require that a pain generator be identified, and in this case a pain generator had not been identified. Further, the reviewer opined that it was unclear whether a decompression alone or a fusion be indicated. Either way Dr. opined that the surgery was not supported by ODG Guidelines.

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

It is my opinion that the adverse determination should be upheld. The medical records provided to me in this case do not meet ODG Guidelines for surgical fusion as a pain generator has not been demonstrated.

**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)**