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Notice of Independent Review Decision

DATE OF REVIEW: 10/13/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient Lumbar Fusion LOS 1-2 days 22558, 64999, 22851
Cybertech TLSO using L0637

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.

Inpatient Lumbar Fusion LOS 1-2 days 22558, 64999, 22851 - Upheld
Cybertech TLSO using L0637 - Upheld

PATIENT CLINICAL HISTORY **(SUMMARY):**

The patient sustained an injury to her lower back on xx/xx/xx. She underwent a lumbar discography in November of 2006 as well as physical therapy, and lumbar fusion surgery was recommended. Medications included Hydrocodone and Darvocet, but according

to an evaluation dated 07/23/08 she had not been taking any medications because she had been out of them.

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

In my opinion, the performance of the fusion surgery on the claimant is neither reasonable, nor necessary. Please see the rationale below.

This patient does not qualify for fusion surgery. She has minimal, if any, degenerative changes on her MRI and they span two levels. Discography was initially positive at two levels and then later surgery was only indicated for one level. There were several problems with this; if the patient had a positive discogram and this level is left out, there is a change that it would become and/or remain painful. Second, surgery based on discography would not yield good results in even psychologically sound patients. While this patient has “minimal” psychological factors, it is unlikely she will benefit from the surgery.

Given the mechanism of injury is a low energy injury, the surgery having been indicated first by discography and then even ignoring discography, the minimal degenerative changes, there is no medical necessity for a surgical procedure at this time.

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)**