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Notice of Independent Review Decision

DATE OF REVIEW: 09/18/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient posterior decompression at L5-S1 and evaluation of the fusion with an intraoperative decision/if psuedoarthrosis is encountered then a posterior lumbar interbody fusion at L5-S1, posterior interbody fixation at L5-S1, bone graft, allograft, bone graft, autograft, iliac crest, bone marrow aspirate with a one to three day length of stay with a purchase of a Cybertech LSO

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 posterior decompression at L5-S1 and evaluation of the fusion with an intraoperative decision/if psuedoarthrosis is encountered then a posterior lumbar interbody fusion at L5-S1, posterior interbody fixation at L5-S1, bone graft,

allograft, bone graft, autograft, iliac crest, bone marrow aspirate with a one to three day length of stay with a purchase of a Cybertech LSO - Upheld

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

This patient has had multiple spinal surgeries for mild degenerative disease. The patient had surgery initially based on a discogram in September 2008, at which time anterior interbody fusions were performed at L3-L4 and L4-L5 by _____, M.D. He underwent an L5-S1 fusion by Dr. _____ on 04/04/02 with removal of segmental pedicle instrumentation and laminectomies in November of 2002. A questionable epidural abscess was diagnosed in October 2003 and Dr. _____ reexplored the spine and had a spinal cord stimulator placed in October 2004. It was later removed. A CT performed in April of 2007 demonstrated a questionable lucency at L5-S1, so in July of 2006, Dr. _____ performed yet another surgical approach. At that time,

the preoperative diagnosis was psuedoarthrosis, but the postoperative diagnosis was a solid lumbar fusion. Even though the fusion was noted to be intact, another fusion was performed at those levels. X-rays of the lumbar spine on

03/20/07 showed a linear lucency at L5-S1, which was thought to raise the possibility of psuedoarthrosis. Dr. _____ removed the spinal cord stimulator on

01/14/08. Dr. _____ notes in April of 2008 demonstrated the utility of the surgery that had been performed. The patient himself told Dr. _____ that he had gotten minimal response from at least five surgeries that had been performed in the past. Dr. _____ diagnosis was psuedoarthrosis and residual severe stenosis at multiple levels with atopic placement of the L5 pedicle screws in the spinal canal. He ordered a CT myelogram and this was performed on 05/28/05. This minimal report indicates there was a solid fusion of all levels from L3 to the sacrum, no evidence of hardware loosening or subsidence, and no evidence of herniated disc or spinal stenosis. The examination performed in June of 2008 demonstrated no physical abnormalities.

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

Further surgery is not going to improve this patient's clinical situation. The last objective imaging does not demonstrate any evidence of stenosis, any evidence of psuedoarthrosis, or any evidence of nerve root impingement. In the absence Of objective disease, there can be no question that surgery is not indicated. Therefore, in my opinion, the requested inpatient posterior decompression at L5- S1 and evaluation of the fusion with an intraoperative decision/if psuedoarthrosis is encountered then a posterior lumbar interbody fusion at L5-S1, posterior interbody fixation at L5-S1, bone graft, allograft, bone graft, autograft, iliac crest, bone marrow aspirate with a one to three day length of stay with a purchase of a Cybertech LSO is neither reasonable nor necessary.

**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 AND 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 (PROVIDE A DESCRIPTION)