



**2<sup>nd</sup> Amended Decision September 11, 2009**  
**REVIEWER'S REPORT**

**DATE OF REVIEW:** 08/30/09

**IRO CASE #:**

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

Lumbar surgery, anterior lumbar interbody fusion, L2-L4, possible increase to L2-L5, posterior spinal fusion, L2-L4, possible inclusion of L4-L5 with instrumentation and bone graft, NTI monitoring

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine injury

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. forms
2. forms
3. Denial letters dated 11/13/08, 06/17/09, and 07/01/09
4. Carrier records
5. Clinical notes, M.D., 24 entries between 11/23/05 and 05/27/09
6. , M.D., nine entries between 03/24/05 and 08/11/09
7. Requestor records
8. MRI scan, lumbar spine, 11/14/07
9. Lumbar discogram, L2/L3, L3/L4, and L4/L5
10. Operative report, nerve blocks, 09/24/08
11. Bilateral facet joint injections, L4/L5, L5/S1, 08/18/08
12. Independent Medical Examination, 03/29/07
13. Letters dated 05/15/09, 11/03/08, and 12/03/07

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is a xx-year-old male who was a passenger in a motor vehicle involved in a motor vehicle accident on xx/xx/xx. He suffered multiple injuries and was hospitalized for several days with cervical, lumbar, and chest injuries. His cervical spine injuries resulted in a surgical procedure in April 2003 including anterior cervical fusion with plate, screws, and bone graft. He has subsequently had little in the way of cervical pain. However, he has had severe, almost unbearable, unrelenting lumbar pain and bilateral lower extremity pain. He has been evaluated by a number of physicians including pain management consultants and orthopedic surgeons. There has been a long-term recommendation for extensive lumbar fusion for degenerative disc disease. Physical examination fails to reveal any evidence of radiculopathy or compressive neuropathy. The recommendations for extensive anterior and posterior lumbar fusion have been considered, reconsidered, and even reconsidered on a number of occasions. On all occasions, the request to preauthorize such a surgical procedure has been denied.

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

There is no evidence of pathologic anatomy as a direct result of the motor vehicle accident. There is no evidence of lumbar spine fracture or subluxation. There is no evidence of instability in the lumbar spine region. Physical findings fail to reveal evidence of neurological compromise. The criteria published in the ODG 2009 Low Back Chapter concerning fusion of the lumbar spines have not been met. There is no documented evidence of instability, which might necessitate lumbar fusion. There is no psychological evaluation, which is recommended. The prior denials of this request to perform an extensive 360-degree spine fusion have been appropriately denied and should be upheld.

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

*(Check any of the following that were used in the course of your review.)*

- 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 national accepted medical literature (provide a description).

\_\_\_\_\_Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)