



Medical Review Institute of America, Inc.  
America's External Review Network

DATE OF REVIEW: November 25, 2009

IRO Case #:

**Description of the services in dispute:**

Preauthorization – Inpatient lumbar surgery, lumbar laminectomy, discectomy arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L4–L5–S1.

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer completed a fellowship in Pediatric Orthopaedic Surgery. This reviewer is a member of the American Academy of Orthopaedic Surgeons and the Pediatric Orthopaedic Society of North America. This reviewer has been in active practice since 2000.

**Review Outcome**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

**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.**

Medical necessity does not exist for the requested Inpatient lumbar surgery, lumbar laminectomy, discectomy arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L4–L5–S1.

**Information provided to the IRO for review**

**Information Submitted By The State:**

Notice of case assignment, 11/9/09

Fax from Texas Department of Insurance, 11/9/09

Confirmation of receipt of a request for review by an IRO, 11/6/09

Request for a review by an independent review organization, 11/4/09

Preauthorization determination, 11/3/09

Preauthorization determination, 10/23/09

List of surgery codes, undated  
Letter from MD, 10/21/09  
Fax 10/19/09  
Clinical interview, 9/29/09  
Office visit note, 8/25/09  
Follow up evaluation, 6/1/09  
Radiology report, 1/15/09  
Consult note, 11/27/07  
Electrodiagnostic evaluation, 3/2/06  
Electrodiagnostic interpretation, undated  
MRI report, 2/17/06

#### Records Received

Request for review by an IRO, 11/4/09  
Preauthorization determination, 10/23/09  
Preauthorization determination, 11/3/09

#### Patient clinical history [summary]

The patient is a male, almost xxxx years status post back injury. An appeal is submitted for the denial of L4–S1 decompression and fusion by Dr. The patient currently complains of back and bilateral (left greater than right) pain. Examination by Dr. details paresthesias in the left L5/S1 dermatomes, "mild" weakness of the left gastrosoleus muscle, and absent left knee and ankle reflexes. Dr. interprets the patient's imaging as showing 4.5 mm translatory discrepancy at L5–S1 and a 22 degree extension angle at L4–5. MRI (magnetic resonance imaging) was done almost xxxx years ago and suggests an L4–5 HNP (herniated nucleus pulposus) to the right. Electrodiagnostics done almost 4 years ago showed right L5 radiculopathy. Pre-surgical psychological evaluation revealed no significant psychological reasons to avoid surgical treatment of the back pain. Conservative treatment is mentioned in the clinical notes, but no documentation of the conservative treatment attempted and failed is presented for review.

#### Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The prior denial is upheld. The patient's clinical scenario is clearly much different now from what it was years ago when surgery was previously indicated by another provider. Work-up to reflect present clinical scenario has not been performed and there is no significant documentation to reflect what conservative treatment has been attempted and failed for the present symptoms. The physical examination findings seem to indicate that a decompression is warranted, however there is no up-to-date imaging to correlate with the examination findings documented by Dr. There is significant discrepancy in radiographic interpretation of possible lumbar instability.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

ODG, Low Back, fusion (spinal)

ODG, Low Back, discectomy/laminectomy