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Notice of Independent Review Decision

DATE OF REVIEW: June 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

In-patient anterior lumbar interbody fusion @ L5-S1 posterior decompression with posterolateral fusion and screws to include CPT code # 22558 and 63047.

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

American Board of Neurological 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:

The patient is a female who underwent a lumbar MRI scan on April 13, 2008. This revealed mild degenerative changes at L5-S1.

The patient saw M.D., on June 11, 2008, with complaint of neck, bilateral shoulder pain, low back pain, and pain radiating to the inner thighs bilaterally. He performed electrodiagnostic studies on the patient. These studies revealed bilateral carpal tunnel syndrome, a left ulnar neuropathy, and a possible right S1 radiculopathy.

The patient underwent another lumbar MRI on September 20, 2008, which revealed a broad protrusion at L4-5 with 20%-30% bilateral foraminal narrowing. The study also revealed a disc protrusion at L5-S1 with 30% bilateral foraminal narrowing.

M.D. saw the patient on December 9, 2008. He noted that she had a work injury on xx/xx/xxxx, and complained of low back pain with intermittent shooting pain in the right lower extremity. Physical therapy had not been beneficial. On examination, she had full strength except for 4/5 strength in the right gastrocnemius. She had decreased sensation in the right L5 and S1 distributions.

On February 4, 2009, the patient underwent a myelogram and CT scan which revealed no canal or foraminal stenosis.

The patient had flexion/extension x-rays of her lumbar spine on February 6, 2009, which revealed no evidence of spondylolisthesis.

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

The patient has no radiographic evidence of nerve root compression. Furthermore, her flexion/extension x-rays do not reveal any instability. Because there is no evidence of instability and no evidence of nerve root compression, she is not a surgical candidate. According to the ODG, a fusion is not recommended for patients unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction. There is no evidence that the patient has either of these.

In addition, studies have revealed that a fusion for low back pain has not resulted in significant improvement on a long-term basis. This is supported again by references in the ODG. Other studies, including researchers who presented the results at the annual meeting of the American Academy of Orthopedic Surgeons in Washington, D.C., Dr. and colleagues from Dartmouth Medical College, found that many patients were inappropriately undergoing a lumbar spine fusion.

In conclusion, the patient does not have evidence of nerve root compression and no evidence of lumbar instability and, therefore, is not a candidate for a surgical fusion.

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)**