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Notice of Independent Review Decision

DATE OF REVIEW: March 3, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Decompression and fusion at L5-S1 herniated nucleus pulposus with 2 day inpatient stay to include CPT codes 20936, RC111, L0637, 22612, 38220, 20938, 22558, 20930, 22840, 63047, and 22851.

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

Diplomate, American Board of 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the URA include:

- Official Disability Guidelines, 2008
- 05/20/08
- 06/2/08, 10/13/08, 11/17/08
- 08/07/08
- M.D., 09/29/08, 11/03/08
- 11/19/08
- 11/26/08, 01/12/09, 02/02/09
- 12/16/08, 01/07/09

Medical records from the Requestor/Provider include:

- Imaging, 05/20/08
- 06/23/08, 10/13/08, 11/17/08
- 08/07/08
- M.D., 09/29/08, 11/03/08
- 11/19/08
- 11/26/08, 01/12/09, 02/07/09
- 12/16/08

PATIENT CLINICAL HISTORY:

The patient is a xx-year-old male who injured his back and neck while driving when he was rear ended. The neck problem resolved, but the low back pain with right lower extremity pain remained and has continued to give him problems. He has not responded to chiropractic treatment.

An MRI was performed, which revealed a central 4-5 mm protrusion with an annular tear at L5-S1. An EMG was also performed, which did not reveal radiculopathy.

The patient has not improved with epidural steroid injections.

A psychological evaluation with MMPI by, deemed him to have no psychological barriers for surgery.

M.D. requested a 360-degree fusion at L5-S1 with anterior and posterior instrumentation.

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

In my opinion, the denial of surgery is appropriate and should be upheld. Flexion and extension views demonstrate no instability as defined by the AMA Guides, 4th Edition, page 98, which states there must be intersegmental motion of one vertebra over another

of greater than 5 mm and/or an angle of greater than 15 degrees between the vertebra at the L5-S1 joint.

Furthermore, spondylolisthesis was not described in the MRI report or the flexion/extension views. There was retrolisthesis described, however, it is not the same as spondylolisthesis.

Moreover, lumbar spinal fusion for degenerative disc disease is not recommended because of poor outcomes, especially in the workers' compensation population. A recent study of 725 workers' compensation patients in Ohio who had a lumbar fusion found that only 6% were able to go back to work a year later, 27% needed another operation, and over 90% were in enough pain that they still required narcotics (ODG, Low Back Chapter, 2008). Additionally, there is no documentation of spinal instability at the L5-S1 level as described (ODG, Low Back Chapter, 2008).

Therefore, based on the above rationale and peer reviewed guidelines, the request for an anterior/posterior fusion at L5-S1 with anterior/posterior instrumentation and a two-day hospital stay is not certified.

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)**