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Notice of Independent Review Decision

DATE OF REVIEW: 11/10/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Extreme lateral interbody fusion with posterior lumbar decompression and fusion

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.

Extreme lateral interbody fusion with posterior lumbar decompression and fusion
- Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by M.D. dated 06/19/06

A Required Medical Evaluation (RME) with M.D. dated 07/18/08
Evaluations with M.D. dated 01/26/09, 03/20/09, 03/23/09, 04/13/09, 05/13/09,
06/15/09, 07/15/09, 08/10/09, and 08/24/09
An MRI of the lumbar spine interpreted by M.D. dated 02/20/09
Preauthorization request forms from Dr. dated 08/14/09 and 09/10/09
A letter of non-certification, according to the Official Disability Guidelines (ODG),
from M.D. dated 08/19/09
A letter of non-certification, according to the ODG, from M.D. dated 09/17/09
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 06/19/06 showed mild postoperative scarring on the right side at L4-L5 and degenerative disc disease at L4-L5 and L5-S1. On 07/18/08, Dr. recommended a psychological evaluation and possible additional surgery. On 01/26/09, Dr. recommended a home exercise program, a new lumbar MRI, a lumbar discogram, and a TENS unit. An MRI of the lumbar spine interpreted by Dr. on 02/20/09 showed a right laminotomy at L4-L5 with enhancing epidural fibrosis and enhancing residual disc and a 7 mm. central/lateral disc protrusion at L5-S1. On 03/20/09, Dr. recommended Flexeril, Lortab, and Cialis. On 05/13/09, Dr. again recommended a lumbar discogram. On 07/15/09, Dr. recommended an extreme lateral interbody fusion of L4-L5 followed by a posterior lumbar decompression and fusion of L4-L5 and L5-S1. On 08/14/09 and 09/10/09, Dr. provided preauthorization forms for the surgery. On 08/19/09, Dr. wrote a letter of non-certification for the surgery. On 09/17/09, Dr. also wrote a letter of non-authorization for the surgery.

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

The patient has multiple levels of degenerative changes in his lumbar spine. Those changes can occur even in individuals without lifting injuries and without discectomy. Also, the pain generators have not been adequately demonstrated. This, as noted above, can exist in asymptomatic individuals. Furthermore, the patient has not had presurgical preparation. The ODG does require, especially in cases of chronic pain, that there be a psychological evaluation and this has not been done. The proposed surgical technique by the operative surgeon is not appropriate even if fusion were indicated. The extreme lateral technique is best at L3-L4 and occasionally effective at L4-L5.

The indications for surgery are not clear and the odds of a patient improving with this type of surgery are extremely low. It has been shown that fusion in the workers' compensation population for degenerative disc disease has been effective less than 50% of the time. Given all the facts above, the requested extreme lateral interbody fusion with posterior lumbar decompression and fusion

is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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)