



**REVIEWER'S REPORT**

**DATE OF REVIEW:** 11/07/09

**IRO CASE #:**

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

Lumbar fusion, L4 through S1

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

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

**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. ZRC forms
2. TDI forms
3. Denial letters 09/03/09 and 09/22/09
4. Requestor records
5. Neurosurgery consultation, Dr., 04/22/09
6. DNI Imaging, discogram, 06/16/09
7. Followup clinical notes, 06/17/09, 08/26/09, with fax cover sheets
8. Preoperative psychological evaluation, 10/13/09
9. MRI scan of lumbar spines, 04/10/09
10. MRI scan of lumbar spines, 12/21/09
11. MRI scan of left hip, 12/21/07
12. Lumbar myelogram and CT scans, 06/27/08
13. Lumbosacral spine x-rays, 09/22/08
14. EMG/nerve conduction studies, 01/14/08 and 04/08/09
15. URI records

16. MRI scan review, 09/03/09
17. Professional review, 09/21/09
18. Chronic pain evaluation, 07/31/08
19. M.D., second surgical opinion, 08/19/09
20. Appeal letters, 08/17/09 and 09/10/09

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

The patient is a male who suffered an injury on xx/xx/xx. He apparently was struck by a . He injured his lumbar spine region and left hip. He underwent left hip replacement surgery. He has continued to complain of low back pain with pain radiating into both lower extremities. His physical examination has failed to reveal objective physical findings of radiculopathy. As late as August 2009, straight leg raising test was negative, and motor and sensory examination failed to reveal evidence of deficits. He does report numbness and tingling radiating from his buttocks into both calves and occasional burning pain in both feet. The patient has undergone extensive nonoperative treatment including physical therapy, lumbar epidural steroid injections, pain medication, activity modifications, and nonsteroidal anti-inflammatory medications. A recommendation has been provided for lumbar fusion from L4 to S1. This recommendation for preauthorization has been considered and denied, reconsidered and denied.

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

The patient suffers what appears to be mechanical low back pain primarily at levels L4/L5 and L5/S1. There has been no effort made to demonstrate instability at these levels. There is no demonstration of neural compressive disease, though there is demonstration of radiculopathy, principally on the basis of symptoms and EMG/nerve conduction studies. Discogram reveals degenerative disc disease at multiple levels including some abnormalities at L3/L4, L4/L5 and L5/S1. The ODG 2009 Low Back Pain Chapter passage on Spine Fusion suggests that primary mechanical back pain should include a demonstration of spinal unit failure or instability. There is a suggestion that spinal fusion for primary mechanical low back pain should be entertained with circumspect as failure rates are particularly troublesome.

**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 judgment, 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.)