

# US Decisions Inc.

An Independent Review Organization  
71 Court Street  
Belfast, ME 04915  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: manager@us-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/01/2009

**IRO CASE #:**

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

Transforaminal lumbar interbody fusion L4-5 with posterior instrumented fusion and micro lumbar discectomy right L5-S1

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

M.D., board certified in Orthopedic Surgery  
Spinal Surgeon

**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**

ODG Guidelines and Treatment Guidelines, Low Back and Pain

Adverse Determination Letter, 9/15/09

, MD, 9/8/09, 7/8/09, 7/13/09, 8/3/09, 5/16/01, 7/11/01, 8/15/01, 12/20/02, 1/31/03, 3/10/03

Lumbar Myelogram and CT scan post myelogram, 7/22/09

MRI of cervical spine, 12/23/08

MRI of lumbar spine, 12/23/08

MD, 11/9/08-9/3/09

Letter from Law Offices, 9/29/09

, 6/2/97, 6/6/97, 4/16/98

, Dr. , MD and Dr. , MD, 1997-2009

Dr. , MD, 1997-2002

Dr. , MD, 11/12/97, 7/29/98

, 1/9/98

, MD, , MD, 1/30/98-11/14/02

Clinic Notes, 3/3/98

Dr. MD, 3/6/98, 1/19/07

Dr. , 6/14/98

Dr. , MD, 7/28/98

Dr. , 9/28/98

Dr. , MD, 9/29/98, 3/10/99

Dr. , MD and Dr. DC, 1/8/99-8/13/07  
Dr. , MD, 4/1/99, 7/1/99  
Dr. , MD, April 1999  
Dr. , PhD, 5/13/99, 8/3/99

Dr. , MD, 5/13/99, 6/1/99  
Dr. , PhD., 6/10/99, 6/29/99  
Dr. , MD, 7/29/99, 8/29/00  
, 8/5/99, 6/14/01  
Dr. , 5/6/02  
, 6/12/02  
Dr. , DO, 2002-2006  
Dr. , MD, 11/19/02  
, MD, 1/22/03  
Radiology, 2/5/03  
Dr. , MD, 10/4/05

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who has complaints related to the cervical spine, lumbar spine, and other body parts. She is currently being treated predominantly for her low back, which is said to be radicular pain, and there are reports of subtle anesthesia. She apparently has some positive straight leg raising on the left and absent reflex in the left ankle, indicative of an S1 pattern. Imaging studies showed 5-mm subligamentous herniation at L5/S1 with some contact of the S1 root. Myelogram plus post myelogram CT scan showed a grade 1 spondylolisthesis of L4 on L5 with no nerve root compromise. The current request is for a fusion at L4/L5 and a decompression of the right S1 root.

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

As far as this patient's L4/L5 level is concerned, while there is noted to be some movement with flexion/extension, this has not been measured, and there is no evidence in the medical records one way or the other whether this conforms to the American Medical Association Guidelines concerning instability, which would place her as a candidate for fusion. As far as the instability at L4/L5 whether this is surgical or not, it has not been documented as a pain generator. In fact, the complaints are primarily axial. Based upon the medical records provided, this reviewer is unable to overturn the previous adverse determination, as the requested surgery at L4/L5 does not meet the Official Disability Guidelines and Treatment Guidelines. The surgery at L5/S1 for the root decompression has been submitted as a package with the L4/L5 level, and the adverse determination cannot be overturned in part. It is for these reasons that the adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Transforaminal lumbar interbody fusion L4-5 with posterior instrumented fusion and micro lumbar discectomy right L5-S1.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)