

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Dec/23/2009

**IRO CASE #:**

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

Remove instrumentation re-fusion of the lumbar spine at L4-5, L5-S1 with 3 day inpatient stay

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

MD, Board Certified Orthopedic 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**

Adverse Determination Letters, 11/6/09, 11/12/09  
MD, 10/6/08-10/23/09  
L-Spine w/o contrast, 10/16/09  
Labs, 2008-2009 Orthopedic Hospital, 11/10/08  
MRI Lumbar Spine, 7/2/08  
ODG Guidelines and Treatment Guidelines, Low Back

**PATIENT CLINICAL HISTORY SUMMARY**

The medical records presented begin with the July 2, 2008 MRI report. Significant disc desiccation with loss of disc height is identified. This has occurred at all five levels of the lumbar spine. At the L4/5 level, a disc herniation is identified. A November 10, 2008 operative report notes that a central laminectomy had been completed at multiple levels.

Subsequent to the surgery, the injured employee appeared to be reasonably well. As of April 17, 2009 it was reported that the fusion mass appeared to be consolidating. It was noted with the September 28, 2009 visit that there were still some complaints of low back pain with radiation into the buttocks. There was some suggestion of a failure of the fusion mass at L5/S1 to be healing properly.

Secondary to ongoing complaints of pain a CT scan was suggested. This study revealed mild to moderate canal stenosis and that the fusion mass was not solid at either level. By October 2009, this was declared to be a pseudoarthrosis. Remove instrumentation re-fusion of the lumbar spine at L4-5, L5-S1 with 3 day inpatient stay was recommended and is the subject of this independent review.

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

The adverse determination letters indicate that no efforts for conservative care to resolve this patient's pseudoarthrosis have been undertaken. As noted in the Official Disability Guidelines, fusion surgery is not recommended in patients who have less than six months of failed conservative care. However, it is indicated if there is objectively demonstrated severe structural instability or a progressive neurologic dysfunction. Based on the records presented the reviewer did not see any evidence of a progressive neurologic dysfunction, only increasing complaints of pain. There is a noted a pseudoarthrosis, however, there are no noted attempts at conservative care. When noting the patient selection criteria listed in the ODG it is clear that the criteria are not met in this patient's case. The records indicate there has been no active intervention to see if this pseudoarthrosis can be resolved in a non-surgical fashion given the comorbidities and other parameters of this case. The reviewer finds that medical necessity does not exist at this time for Remove instrumentation re-fusion of the lumbar spine at L4-5, L5-S1 with 3 day inpatient stay.

**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)