

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Dec/30/2009

**IRO CASE #:**

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

Inpatient lumbar surgery to include: lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator (BGS) (EBI) at L4-5-S1 with two (2) days length of stay (LOS).

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

MD, Board Certified Orthopedic Surgeon  
Board Certified Spine 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, 11/18/09, 12/7/09

M.D. 5/20/09, 4/20/09, 11/26/08

M.S.,M.D. 6/29/09

Physical Therapy 6/23/09

M.D., P.A. 5/12/09, 5/11/09, 9/2/09

Imaging Center 5/7/09

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who was injured on xx/xx/xx while at work. There was an MRI scan performed, which shows the patient has a mild circumferential disc bulge with central annular tear at L4/L5 with no central canal lateral recess or foraminal stenosis. At L5/S1 there is a minimal disc bulge and a tiny central superimposed disc protrusion and annular tear without stenosis. This reviewer did not find a discogram within the medical records. The current request is for a two-level discectomy and fusion for discogenic back pain.

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

While flexion and extension films have been performed, the requested physician concludes that because there is loss of disc space height, this meets the AMA screening criteria for instability. In fact, this is not the case, and there is no documentation noted in the chart of any rotational or translational motion as required to document instability. Given the lack of

documented instability and the lack of pathology on the MRI scan that would be indicative of the necessity for spinal fusion and the lack of identification of a pain generator, this patient does not meet the Official Disability Guidelines and Treatment Guidelines criteria for fusion. The pain generator has not been identified, instability has not been identified, and the treating physician has given no reason why the Official Disability Guidelines and Treatment Guidelines should be set aside. It is for this reason the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Inpatient lumbar surgery to include: lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator (BGS) (EBI) at L4-5-S1 with two (2) days length of stay (LOS).

**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)