

# US Decisions Inc.

An Independent Review Organization  
2629 Goldfinch Dr  
Cedar Park, TX 78613-5114  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: manager@us-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/05/2010

**IRO CASE #:**

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

L4-5 L5-S1 Transforaminal Lumbar Interbody Fusion (T-LIFs) and Lateral Mass Fusion with Podicle Screw Fixation and 1 - 3 Day Inpatient Length of Stay (CPT 22612 22614 22630 22632 63047 63048 22842 22851 20931)

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

M.D., Board certified in Orthopedic Surgery  
Board certified in Spine 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines, Low Back Chapter, Patient Selection Criteria for Lumbar Spinal Fusion

Denials for Requested Services, 5/10/10, 6/7/10

Medical Center 5/28/08 to 5/6/10

Institute of America 6/2/10, 5/19/10

MD 6/1/10, 1/18/10, 7/15/09

Ph.D. 4/15/10, 3/16/10, 5/12/10, 2/10/10

Diagnostics Healthcare 12/1/09, 8/10/09

Rehab 1/23/09 to 11/9/09

DO 8/26/09, 8/19/09

M.D. 8/14/09

Radiology Report 12/2/09

M.D. 5/13/09

5/12/09

Health and Medical 1/21/09

South Loop MRI 1/16/09

M.D. 3/15/10

FAE 3/15/10

Pain Management Center, 7/14/09, 9/17/09  
D.O. 2/18/09  
FCE 1/14/09  
Family Clinic 12/1/08  
Surgery Specialty Hospitals 8/11/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female who was injured on xx/xx/xx while working. According to the records, she has had two-level discogenic back pain. She has been treated with medication, physical therapy, injections, and activity restrictions. According to MRI, there is questionable spondylolysis of at least one of the pars interarticularis at L5. The patient has minimal grade 1 spondylolisthesis at L5-S1. The patient has not had any previous laminectomies. The patient does not have any significant radiculopathy and there is no evidence of any segmental instability within the medical records. The request is for a two-level lumbar fusion.

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

I have reviewed the Official Disability Guidelines & Treatment Guidelines for spinal fusion. I have also reviewed the AMA Guides. According to ODG, a fusion should be considered where there is segmental instability such as that which occurs with a true spondylolisthesis. In this case, there is no objectively demonstrated evidence that states this patient has a spondylolytic defect. There is no evidence in the medical record that there is indeed instability of any nature and certainly not any relative angular motion of greater than 20 degrees. Based upon this, this patient does not meet the criteria for fusion. The provider has not explained why the ODG Guidelines should be set aside in this particular case. It is for this reason that the previous adverse determinations cannot be overturned. The reviewer finds that medical necessity does not exist for L4-5 L5-S1 Transforaminal Lumbar Interbody Fusion (T-LIFs) and Lateral Mass Fusion with Pedicle Screw Fixation and 1 - 3 Day Inpatient Length of Stay (CPT 22612 22614 22630 22632 63047 63048 22842 22851 20931).

**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: AMA GUIDES)