



14785 Preston Rd. Suite # 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision
Amended and sent 12/08/2011

DATE OF REVIEW: 11/28/2011

Date of Amended Decision: 12/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-5, L5-S1 ALIF , Pos fusion, Instrumentation, laminectomy/ facetectomies

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

M.D. Board Certified in Orthopedic Surgery Fellowship Trained 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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	11/08/2011
Health Care Workers' Comp Services Utilization Review Determinations	10/18/2011-11/03/2011



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M.D. Prescriptions for: NCV/EMG, Caudal Epidural Steroid Injection Under U/S Guidance Therapy 3 times 1 week x 4 weeks	11/01/2011
Physical Therapy, PC Request For Pre-Authorization Re-Evaluation	10/20/2011 10/18/2011
M.D. Letter of Reconsideration Pre-Authorization Request	10/20/2011 10/19/2011
Solutions, PA Office Visit Notes	6/13/2011-7/252/2011
Cat scan & MRI Center Radiology Reports	6/17/2009-7/20/2011
Technologies MRI Lumbar spine without Contrast	6/17/2009
Pre-Surgical Consultation and Behavioral Assessment	9/03/2011
Pain Center Office Visit Notes	11/09/2010-3/10/2011
Neurosurgical Association Office Visit Note	1/05/2010
P.A. Office Visit Note	9/20/2011
Physical Therapy Evaluation Fuctional Capacity Evaluaion	6/03/2009-7/16/2009 5/27/2009
Encounter Progress Notes	7/31/2009-8/12/2009

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who sustained acute onset of low back pain and leg pain while at work after lifting a load on xx/xx/xx. CT L-Spine Post Myelogram dated 7/20/2011 showed a central and Paracentral disc Protrusion at L5-S1 level with obliteration of epidural fat and impingement on thecal sac. Downward displacement of both S1 nerve roots. Central and paracentral disc protrusion on the right side at L4-L5 level with obliteration of epidural fat and impingement on thecal sac. Facet hypertrophy and facet subluxation on the right side at L4-L5 level. No evidence of Spondylolysis or Spondylolisthesis. Surgeon wants to proceed with facetectomies at L4-L5 and L5-S1 with an L4-S1 Anterior Lumbar Interbody Fusion (ALIF) to stabilize the spine after the facetectomies.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The requested Lumbar Fusion is not Medically Necessary.



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Per ODG Guidelines, Lumbar Fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the patient selection criteria.

Although this patient has had greater than six months of conservative care, it appears his chief complaint is low back pain, with secondary complaints of bilateral leg pain. His low back pain is believed to be secondary to the degeneration at the discs. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Although a strong case can be made for proceeding with a decompression, a recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion.

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

- 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 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



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- 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:
 1. Foraminal Stenosis and Single-Level Degenerative Disc Disease: A Randomized Controlled Trial Comparing Decompression With Decompression and Instrumented Fusion. Spine. 2007; 32(13):1375-1380.