



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

## Notice of Independent Review Decision

**DATE OF REVIEW: 11/30/2011**

**IRO CASE #:**

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

T12-S1 PEDICAL SCREWS PLACEMENT & POSTEROLATERAL FUSION. POSSIBLE L4-S1 LAMINECTOMY & 3 DAYS HOSPITALIZATION.

**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)



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## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who had undergone L2-L4 Fusion in xx/xx. She developed postoperative back and leg pain. Over the past year she has been complaining of moderate to severe low back pain radiating to the legs. Her conservative treatment included the following medications: Celebrex, Lovastatin, Gabapentin, Triamterene, Estradiol and Amlodipine with no lasting result, and three Epidural Steroid Injections performed but patient states they didn't work. Due to persistent symptoms, further diagnostic studies were performed to include a CT Myelogram on 2/14/2011 that showed severe degenerative disc disease (DJD) L4-5 with severe right foraminal stenosis, and moderate left foraminal stenosis. Moderate right foraminal stenosis L5-S1. Mild canal stenosis L1-L2. Advanced DJD T12-L1 without significant narrowing. The NCS/EMG studies were negative for acute or chronic lumbar radiculopathy. Due to the persistent pain and failure of conservative treatment, the attending physician is requesting fusion of the adjacent degenerating disc at L4-L5 via an L4-S1 ALIF and posterolateral arthrodesis with pedicle screw instrumentation.

### **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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The treatment of lumbar degenerative disc disease and adjacent segment disease with fusion is not warranted. "In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." (ODG Guidelines) "Pain improvement and functional outcomes for many patients undergoing surgery for ASD appear to be relatively poor. Of the 14 patients who all underwent decompression and extension of fusion by Whitecloud et al, most had no improvement or only modest improvement of discomfort with persistent functional limitations and continued need for pain medications." (reference 2,3)

**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
- 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: