



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

Notice of Independent Review Decision

DATE OF REVIEW: 7/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

TWO- DAY INPATIENT STAY FOR LUMBAR HARDWARE REMOVAL
AND OPEN 360 FUSION OF L2-L4
733.90

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

M.D. Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

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	6/23/2011
Management Fund Fax Texas Department of Insurance-IRO Submission Utilization Review Agent Determinations	6/23/2011 4/26/2011-5/10/2011
Back Institute Behavioral Medicine Evaluation Follow-up Consultation- D.O. Radiology Report	4/19/2011 3/16/2011 2/16/2011 2/16/2011
Regional medical Center Imaging Report	2/24/2011
CAT SCAN MRI XR L-Spine	2/15/2011
Imaging Center M.D. MR- Lumbar Spine W/O Contrast	11/05/2010
Surgery Center Operative Reports	8/06/2010-12/09/2010
Designated Doctor Examination M.D.	2/01/2010
M.D. Office Visits	10/29/2010-3/02/2011
Prospective Review (M2) Response 86 pages M.D.	6/27/2011
Clinical Note	1/21/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female with a date of injury xx/xx/xx when she fell at work. She complains of low back pain. She is status post left L2-L3 discectomy on 12/04/2000 and a posterolateral fusion from L2-L4 on 10/18/2002. She did well until she fell at work on xx/xx/xx. On 08/16/2010, she underwent left L5 and S1 selective nerve root injections. On 12/09/2010 she underwent a left L4 selective nerve root injection. She complains of buttock pain, moreso on the left side. Her neurological examination 02/16/2011 is normal. An MRI of the lumbar spine 11/05/2010 shows postoperative changes at L2-L4. There is bilateral neuroforaminal narrowing at L2-L3, particularly on the left. At L3-L4 there is bilateral neuroforaminal narrowing, particularly on the left. At L4-L5 there is bilateral neuroforaminal narrowing with a minimum degree of retrolisthesis. At L5-S1 there is a grade I anterolisthesis with endplate irregularity. At L1-L2 there is a grade I anterolisthesis with mild central and bilateral neuroforaminal narrowing. Due to a disc

bulge there is compression of L5 and S1, particularly on the right. There is a moderate degree of levoscoliosis with the apex centered at the L3 level. Plain films of the lumbar spine 02/15/2011 show normal alignment with no movement on flexion and extension. A bone scan from 02/24/2011 is negative for fracture or metastatic disease. There is a sclerotic lesion in the first sacral segment that is negative on bone scan. A behavioral medicine evaluation 04/19/2011 found a fair to good prognosis for the procedure. She smokes a third to half a pack of cigarettes per day, but is planning on discontinuing this in anticipation of surgery. The provider is requesting an inpatient removal of lumbar hardware and open 360 fusion at L2-L4 for a pseudoarthrosis.

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

The requested surgery is not medically necessary. There is no independent radiology report that details the pseudoarthrosis. According to the ODG, “Low Back” chapter, revision “surgery for failed previous operation” may be indicated “if significant functional gains are anticipated.” As there is no independent radiology report detailing the pseudoarthrosis, medical necessity cannot be established, based on the documentation submitted for review.

References/Guidelines: ODG, “Low Back” chapter

Lumbar fusion is indicated: Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.

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



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- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES