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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 06/24/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior posterior lumbar fusion with instrumentation at L5-S1 and a two day inpatient length of stay

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

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Anterior posterior lumbar fusion with instrumentation at L5-S1 - Upheld
Two day inpatient length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 05/08/03 showed a moderate size right L5-S1 herniated disc with extruded fragment. On 05/14/10, Dr. recommended a CBC and sed rate, a possible CT-guided biopsy, and possible rehabilitation. An MRI of the lumbar spine interpreted by Dr. on 05/14/10 showed a previous L5-S1 laminectomy and discectomy with mild disc protrusion, moderate L5-S1 endplate edema and disc edema, and mild L4-L5 degenerative disc disease. A CT-guided L5-S1 biopsy was performed by Dr. on 06/11/10. On 06/14/10, Dr. found no direct result between the current symptoms and the original injury. On 06/21/10, Dr. recommended surgery at L5-S1. A lumbar ESI was performed on 11/03/10. On 12/06/10, Dr. felt the patient's compensable injury was limited to a herniated disc at L5-S1 and right lumbar radiculopathy. On 12/27/10 and 01/18/11, denied the lumbar surgery. On 04/06/11, Dr. recommended a trial of physical therapy, a repeat MRI, routine x-rays, laboratory studies to rule out an infection, and a possible fusion. On 04/08/11, Mr. requested three hours of mental health testing. On 04/14/11, wrote a letter of denial for a lumbar MRI. On 05/16/11 and 05/23/11, Dr. recommended a lumbar fusion at L5-S1. On 05/17/11 and 05/24/11, carrier wrote letters of denial for the lumbar fusion, according to the ODG.

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

The patient sustained a disc herniation in XXXX. The criteria for lumbar fusion have not been met as noted in the Official Disability Guidelines (ODG). All the pain generators have not been identified or treated, there is no instability, and there is no evidence that the patient has been treated aggressively with physical therapy. There is no evidence of infection, tumor, or deformity. There has only been one discectomy on the disc. In the absence of a sustained physical therapy program and a behavioral evaluation, she is not a suitable candidate. The patient does not meet the criteria set forth in the ODG for lumbar fusion. Therefore, the requested anterior/posterior lumbar fusion with instrumentation at L5-S1 and a two day inpatient length of stay is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)