



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision
Amended and Sent on 4/13/2012

DATE OF REVIEW: 4/12/2012

Date of Amended decision: 4/13/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Transforaminal Lumbar Interbody Fusion L4-5 with Expedium Devex, Laminectomy L3-4, removal of Posterior Segmental Fixation L4-S1 and bone graft of the right Posterior Iliac with four (4) days inpatient stay.

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 Spine Surgeon.

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
Notice of Case Assignment	3/23/2012
Notice of Utilization Review Findings	2/23/2012-3/21/2012



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Evaluation Notes	1/16/2012-2/13/2012
Diagnostic Outpatient Imaging	
Radiology Report	2/08/2012
Department of Radiology Radiology Report	11/23/2003
Physicians Hospital Operative Report	8/08/2007
Operative Procedure Reports	11/20/2001-11/30/2004
Office Visit: Pump Follow up	10/31/2007

PATIENT CLINICAL HISTORY [SUMMARY]:

Injured Worker sustained a low back injury in xxxx that was subsequently treated with three back surgeries resulting in an L4 to S1 posterior lumbar fusion with instrumentation and decompression. Over the past 3 years at least, the injured worker continues to complain of chronic low back pain and thigh pain. In addition to the lumbar fusion, he is also s/p morphine pump placement and DCS placement.

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

The requested lumbar surgery is not medically necessary.

Rationale: Per ODG references, 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. Lumbar Fusion is recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the patient selection criteria. In the current case, there is no evidence of such instability. Furthermore, the attending physician's indication of pseudoarthrosis is not clearly supported by the radiologist's findings that lack any mention of a pseudoarthrosis. In addition, 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. The patient is on chronic opioids, has a morphine pump, and a dorsal column stimulator with a neuropathic pain profile. 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." Although the CT Myelogram reports moderate stenosis at L3 L4, there appears to be no indication of any diagnostic ESIs that may be considered prior to surgical laminectomy.



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**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