



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

Notice of Independent Review Decision

**DATE OF REVIEW:** 6/03/2012

**IRO CASE #:**

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

Inpatient LOS 1 day Laminectomy with fusion and instrumentation L3-4 and removal of spinal cord stimulator battery and TLSO back brace purchase.

**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
Texas Department of Insurance Notice of Case Assignment	5/14/2012
Insurance Company Utilization Review Findings Response Regarding Disputed Services	4/27/2012-5/09/2012 5/15/2012
Hospital Operative Reports Radiology Reports	1/03/2007-3/23/2012 4/29/2008-3/23/2012
Clinic Office Visit Notes Physical Therapy Treatment Record	12/21/2005-2/17/2012



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M.D. Initial Office Consultation	7/23/2009
M.D. Patient's Visit Reports	10/07/2010-4/16/2012
M.D. Designated Doctor Evaluation Report	9/27/2007 2/02/2007-4/01/2007

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient sustained a work-related low back injury in xx/xx/xx that resulted in eventual L4-S1 posterior lumbar decompression and fusion has developed adjacent segment disease at L3-L4 (disc degeneration and spinal stenosis). Dr. note dated 4/16/2012 states that the patient has severe mid-lumbar pain with bilateral radiating hip and leg pain, worse on the right. He has diminished mobility of the low back, and loss of strength from the quadriceps distally and diminished sensation in the right L4 dermatome. Physician's request is for in-patient length of stay for one day, lumbar laminectomy with fusion and instrumentation L3-4 and removal of spinal cord stimulator battery and TLSO back brace purchase.

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

The request for in-patient length of stay for one day, lumbar laminectomy with fusion and instrumentation L3-4 and removal of spinal cord stimulator battery and TLSO back brace purchase is not medically necessary.

Per ODG references, 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). In addition, the indication for removal of the DCS is not clearly defined.

Finally, there is no a clear indication of an exhaustive conservative workup such as therapy, medications, and pain management to address the patients complaint, nor is there any objective radiological reports to support instability at the L3-L4 segment.



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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: