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Notice of Independent Review Decision
Amended and Sent on 4/23/2013

DATE OF REVIEW: 4/15/2013

Date of Amended Decision: 4/23/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-L5 L5-S1 Translateral Interbody Fusion with Spinal Monitoring,
3 days Inpatient Hospital 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
Texas Department of Insurance Notice of Case Assignment	3/26/2013
Comp Services Utilization Review Recommendation Letter Notification of Adverse Determination	3/18/2013 1/30/2013
MD Clinical Notes	1/23/2013-2/28/2013
Imaging MRI Lumbar Spine Reports	10/24/2011-9/28/2012
Radiologics Radiographic Report	8/24/2012
Healthcare Nerve Conducting Studies Report	9/25/2012



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Rehab Specialists New Patient Evaluation Report	3/07/2013
Behavioral Medical Solutions Presurgical Behavioral Evaluation	3/18/2013

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who had a work related injury on xx/xx/xx. He jumped off a 5 foot bobtail and experienced acute onset of low back pain radiating into the right leg. Patient was treated conservatively for his complaints to include physical therapy, activity modifications, and injections. Despite continued care, he continued to be symptomatic, and further diagnostic workup to include a repeat MRI and EMG and NCS were done in the Fall of 2012. The EMG was weakly positive for a right sided L4 and L5 radiculopathy correlating with the patients examination findings to include a positive right straight leg raise despite the MRI which showed primarily but not exclusively left sided foraminal stenosis at L4L5 and L5S1. Due to continued complaints of back and right leg pain, and due to failure of conservative care, a request is made by Dr. for a fusion and decompression.

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

Per ODG references the requested L4-L5 L5-S1 Translateral Interbody Fusion with Spinal Monitoring and 3 days Inpatient Hospital Stay is medically necessary. Despite poorer outcomes in the workers compensation patient undergoing fusion back surgery, the patient in this case has been symptomatic for over a year despite conservative care. He was recently seen by Dr., at Rehab specialists and in his notes it appears that a thorough examination was done to correlate the patient's examination findings with his complaints and MRI findings although it seems odd that there is more left sided stenosis on the MRI and the patient has right sided leg pain. Nonetheless, in summary, there is sufficient documentation to support the above surgical procedure.

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 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



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