



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

Notice of Independent Review Decision

DATE OF REVIEW: 8/13/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthrodesis, Anterior Interbody Technique, including minimal discectomy to prepare interspace (other than for decompression); Lumbar.

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	7/25/2013
Notices of Adverse Determination	7/02/2013-7/15/2013
Pre- Authorization Request Appeal	7/01/2013 7/15/2013
Preauthorization Request	6/27/2013
Transcriptions	1/8/2013-1/22/2013-
Surgical Assessment	5/23/2013
Radiology Report	1/31/2003
Office Visit Notes	2/26/2013-6/18/2013
Procedure Note	4/01/2013



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PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who sustained a low back injury on xx/xx/xx. His chief complaint is low back pain that radiates to the legs. His examination shows pain with lumbar movement, limitation of lumbar range of motion due to pain, and tenderness on palpation in the lumbar region. A trial of conservative care to include pharmacotherapy, physical therapy, and injections were administered with minimal relief. An MRI on 01/31/2013 in the region of the interested surgical segment showed "slight posterior disc height reduction and partial desiccation, 2 mm radial posterior central, 3 mm radial bilateral posterolateral spondylotic disc bulge, annular fissure, and mild facet and flavum hypertrophy."

Due to failure of conservative care, surgical intervention is requested.

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

Per ODG References the requested "Arthrodesis, Anterior Interbody Technique, including minimal discectomy to prepare interspace (other than for decompression); Lumbar" are not medically necessary. Although the patient continues to be symptomatic, the requested procedure is not clinically indicated. The MRI findings are minimal, without any significant MRI evidence of degeneration, herniation, or instability. The 2 mm disc bulges are not significant. Per ODG, 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, but 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. In addition, the patient has failed all conservative modalities, giving poor support for any further intervention to likely change the outcome.

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