



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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Notice of Independent Review Decision  
Amended and Sent on 3/06/2014

**DATE OF REVIEW: 2/06/2014**  
**Date of Amended Decision: 3/06/2014**

**IRO CASE #**

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

Surgery L3-4, L4-5, L5-S1 decompression, posterior spinal fusion, posterior lumbar interbody fusion with instrumentation, autograft, allograft, nucell DME (lumbar back brace).

**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**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a male who injured his back on xx/xx/xx. He complains of low back pain radiating to both legs. Symptoms are not getting better despite therapy, injections and medications. Due to failure of conservative, request is made for a 3 level L3-S1 posterior decompression with fusion. His examination shows pain with flexion and extension and bilateral subjective lower extremity weakness 4/5 strength. EMG is unremarkable. MRI shows age appropriate degenerative changes without frank central or lateral recess stenosis or spondylolisthesis save 2-3 mm degenerative listhesis.



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

Per ODG references, the requested "surgery L3-4, L4-5, L5-S1 decompression, posterior spinal fusion, posterior lumbar interbody fusion with instrumentation, autograft, allograft, nuCell DME (lumbar back brace)" is not medically necessary.

A 3 level fusion without significant stenosis or instability has a higher than usual failure rate, particularly in workers' compensation patients. Despite failure of conservative care, surgical fusion of three levels in this case may risk failed back syndrome and necessity for chronic pain management thereafter. There are not enough findings on the MRI to warrant such a procedure.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- 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