



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/22/2008

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of a PLIF L5/S1 w/2 days LOS (22630, 22612, 22840, and 22851).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

The reviewer is a board certified Orthopedic Surgeon who has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a PLIF L5/S1 w/2 days LOS (22630, 22612, 22840, and 22851).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following party:  
Dr.

These records consist of the following (duplicate records are only listed from one source): Records received from Dr. History and Physical-10/22/07; Progress Notes-11/7/07&1/24/08; Physician's order sheet-2/14/08; Hospital at lab results-3/27/08, CR spine lumbar series report-11/16/07, MRI L-spine w/o contrast report-9/28/07, and CR spine FEX/EXT lumbar-3/7/08; Dr. report-2/21/08; Dr. report-1/14/08; Dr. letter-10/22/07, 11/7/07, 12/13/07, 1/24/08, &

2/6/08; Clinic appeal request-3/10/08; I denial-3/19/08 & 2/8/08; Dr. report-9/18/07.

Records received: Pre-authorization denial-3/10/08, 3/11/08 & 3/19/08; Clinic pre-authorization request-3/5/08; ODG-Fusion (spinal).

A copy of the ODG was provided by the URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male injured at work when he stepped wrong and fell. He complains of persistent lumbar pain with pain into his left leg and foot, and numbness in his left leg. MRI reveals L5/S1 spondylolisthesis and left HNP. Flexion extension x-rays reveal L5S1 grade 1 spondylolisthesis with no instability according to Dr, the radiologist. EMG reveals S1 radiculopathy. The patient has tried and failed conservative treatments. Exam reveals positive SLR on left, decreased sensation in the L5 distribution, and left ankle dorsiflexion weakness. The patient previously smoked and has stopped. Dr reports the patient has no psychiatric symptoms that warrant evaluation. A second opinion concurred with recommendations for surgery.

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

The reviewer states that the patient does not meet the acceptable criteria for fusion per the ODG, no arch defect, instability, infection, tumor or deformity causing pain, neurological deficit or functional disability.

ODG cite:

Patient Selection Criteria for Lumbar Spinal Fusion:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical disectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. 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. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than

4.5 mm). (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria.

**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 (PROVIDE A DESCRIPTION)**