

## Applied Resolutions LLC

*An Independent Review Organization*  
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**DATE OF REVIEW:** 08/11/2008

**IRO CASE #:**

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

Inpatient transforaminal lumbar interbody fusion

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

### **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**

Denial letters-6/5/08; 6/20/08

Dr. -10/19/07; 4/11/08; 6/11/08;

MRI of the cervical and lumbar spine reports 5/11/07

-X-ray of the lumbar spine 6/19/08

-X ray of the lumbar and cervical spine 4/5/07

-4/11/07-04/13/2007, 04/16/2007, 04/20/2007, 04/25/2007, 04/27/2007, 04/30/2007, 05/08/2007, 05/10/2007, 5/11/07

Operative Report Epidural steroid injection at L5-S1 7/23/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This xx year-old female has a date of injury xx/xx/xx, when she was involved in a motor vehicle accident. She complains of low back pain radiating to the buttocks and back of the thigh. She has had physical therapy and one lumbar epidural steroid injection. An MRI of the lumbar spine 05/11/2007 reveals annular bulge and ligamentum hypertrophy with moderately severe canal stenosis. L5-S1 is described as “normal”. No movement is seen on flexion and extension on plain films of the lumbar spine performed

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

The lumbar fusion is not medically necessary. It is not clear from the submitted documentation that L5-S1 is a pain generator given that the MRI is described as “normal” at L5-S1. There are no imaging studies to indicate any abnormality at L5-S1. According to the ODG, “Low Back” chapter, **Preoperative surgical indications for fusion:** “(3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology”. This is not demonstrated at the L5-S1 level. Therefore, the surgery is not medically necessary.

### **References/Guidelines**

ODG “Low Back”

ODG “Low Back” chapter

### **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 - Spondylytic 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). ([Andersson, 2000](#)) ([Luers, 2007](#))] (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). ([Andersson, 2000](#))] (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. (See [ODG Indications for Surgery -- Discectomy](#).)

**Pre-Operative Surgical Indications Recommended:** Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

**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)**