

True Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: February 12, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for 360 degree Polar fusion of L4-5 and L5-S1

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

Board Certified Orthopedic 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

No ODG Guidelines

MRI lumbar, 11/02/07

Office note/consult, Dr. 11/27/07

Denial Letters 12/10/07 and 12/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female xxxx who sustained a low back injury while lifting a patient. Limited records were provided for review. The claimant reported bilateral gluteal pain with lower extremity tingling and intermittent numbness in both feet. A lumbar MRI performed on 11/02/07 noted L4-5 degenerative disc disease with a five millimeter posterior disc protrusion with associated mild to moderate central canal stenosis, as well as L5-S1 disc desiccation and three millimeter posterior disc protrusion without associated nerve root displacement or canal stenosis. Physical examination demonstrated spasms, tenderness, increased back pain with left straight leg raise and intact strength. The claimant is a smoker and treated conservatively with physical

therapy, medications and epidural steroid injection. A 360 degree fusion at L4-5 and L5-S1 has been recommended.

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

Review of the records provided would find that there is no medical necessity for a 360 degree polar fusion at L4-5 and L5-S1 at this juncture based on a careful review of all medical records, and ODG guidelines. Specifically, there is no evidence that the patient failed six months of conservative measures. It has now been four months since the injury. There is no documentation of use of something stronger to break the inflammation cycle such as a Medrol-Dosepak or steroids. It is unclear which type of epidural steroid injections were performed and what symptoms were or were not relieved, nor were any facet blocks performed that the Reviewer is aware of. There is further no evidence of mechanical instability or motion segment instability. And lastly, not all pain generators have clearly been identified and treated and there has not yet been a psychologic screening to evaluate for fusion in this what appears to be otherwise healthy woman.

Thus based on all of the above the Reviewer cannot recommend this as medically reasonable or indicated based on review of the records provided and evidence based medicine. Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back. Fusion.

Low back; fusion.

Not recommended for patients who have less than six months of failed conservative care unless there is 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 selection criteria outlined in the section below entitled,

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 unilateral neural arch hypoplasia.
- (2) Segmental Instability - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy.
- (3) Primary Mechanical Back Pain/Functional Spinal Unit Failure, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability, with and without neurogenic compromise. 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.
- (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.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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.

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)