

**C-IRO, Inc.**  
**An Independent Review Organization**  
7301 Ranch Rd. 620 N, Suite 155-199  
Austin, TX 78726

Notice of Independent Review Decision

**DATE OF REVIEW: SEPTEMBER 25, 2008**

**IRO CASE #:**

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

Anterior Interbody Fusion L5-S1; Retroperitoneal exposure and discectomy L5-S1; Anterior Interbody Fixation L5-S1; Posterior decompression L5-S2; Transverse process fusion L5-S1, Posterior internal fixation L5-S1; Bone Graft Allograft, Bone Graft Allograft in situ, Bone graft Autograft iliac crest; Bone marrow aspirate; inpatient 3-day stay

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

MD, Board Certified Neurosurgeon

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for Anterior Interbody Fusion L5-S1; Retroperitoneal exposure and discectomy L5-S1; Anterior Interbody Fixation L5-S1; Posterior decompression L5-S2; Transverse process fusion L5-S1, Posterior internal fixation L5-S1; Bone Graft Allograft, Bone Graft Allograft in situ, Bone graft Autograft iliac crest; Bone marrow aspirate; inpatient 3-day stay.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 8/12/08, 9/2/08  
ODG Guidelines and Treatment Guidelines

Request for Preauthorization, 8/3/08  
MD, 8/1/08, 10/5/07, 6/6/07, 4/30/07, 4/4/07  
Behavioral Health Assessment, 10/23/07  
Lumbar Spine MRI, 3/14/07  
MD, 3/1/07  
Back and Neck Clinic, 3/1/07  
DC, 9/15/08, 2/20/07, 10/9/07  
Medical Progress Evaluation Notes, 12/26/07, 10/17/07, 2/21/07  
Evaluation Center, 9/17/07  
9/21/07  
MD, 5/1/07  
Emergency Department Medical Records,  
Lumbosacral Spine, 4 Views, 2/20/07

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

This is a male with a date of injury xx/xx/xx when he was lifting . He complains of low back pain extending into the bilateral thighs. He has had chiropractic therapy, an epidural steroid injection, PT and a TENS unit. Neurological examination reveals hyporeflexia of the right knee. Electrodiagnostic studies 03/01/2007 indicate bilateral L4-L5 radiculopathies and a left S1 radiculopathy. MRI of the lumbar spine 03/14/2007 shows early disc dessication at L5-S1 and a 2mm disc protrusion. There is moderate narrowing of the right neuroforamen with effacement of the exiting L5 nerve root. He quit smoking about two months ago. He has had a psychological evaluation.

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

The reviewer finds that the requested procedure is medically necessary. The patient has had a long course of conservative therapy and still is having mechanical back and leg pain. His imaging studies reveal abnormalities at L5-S1. The reviewer agrees that this is his likely pain generator. He has quit smoking and has had a psychological evaluation that has cleared him for surgery. The patient meets the ODG criteria for lumbar fusion, as listed below.

The reviewer finds that medical necessity exists for Anterior Interbody Fusion L5-S1; Retroperitoneal exposure and discectomy L5-S1; Anterior Interbody Fixation L5-S1; Posterior decompression L5-S2; Transverse process fusion L5-S1, Posterior internal fixation L5-S1; Bone Graft Allograft, Bone Graft Allograft in situ, Bone graft Autograft iliac crest; Bone marrow aspirate; inpatient 3-day stay.

### **References/Guidelines**

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 - 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 discectomy. [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)