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Notice of Independent Review Decision

DATE OF REVIEW: January 19, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar anterior and posterior fusion with application of biomechanical device, vertebral corpectomy, anterior lumbar laminectomy with decompression of nerve roots, posterior non-segmental instrumentation, and allograft to include CPT code 22808, with a two (2) day length of stay and purchase of a lumbar back brace.

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

Diplomate, American Board of Orthopedic Surgery

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

Medical records from the Carrier include:

- Employer's First Report of Injury or Illness
- Medical & Surgical Group, 05/05/08, 05/07/08
- Physical Therapy Progress Notes, 05/06/08, 05/07/08, 05/08/08, 05/09/08, 05/12/08
- Diagnostic Center, 05/12/08
- Companies, 05/22/08
- Orthopaedics and Sports Medicine, 05/29/08, 06/10/08, 06/16/08, 07/21/08, 08/20/08
- Physical Therapy, 06/09/08
- Medical Center, 07/08/08
- Inc., 12/10/08, 12/23/08
- Attorneys at Law, 01/09/09

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Orthopaedics and Sports Medicine, 05/29/08, 06/10/08, 06/16/08, 07/07/08, 07/21/08, 08/20/08, 09/19/08
- Medical Center, 07/08/08
- Radiological Center, 10/10/08
- Inc., 12/10/08, 12/23/08

Medical records from the Provider include:

- Orthopaedics and Sports Medicine, 01/07/09
- Diagnostic Center, 05/10/08, 05/29/08
- Orthopaedics and Sports Medicine, 05/29/08, 06/10/08, 06/16/08, 07/07/08, 07/21/08, 08/20/08, 09/19/08, 10/20/08, 11/11/08
- M.D., 07/07/08
- Medical Center, 07/08/08
- Radiology Center, 10/10/08
- Surgery Center, 11/18/08

PATIENT CLINICAL HISTORY:

The patient sustained a back injury while moving a ladder on top of a roof, which resulted in a far lateral left L3-4 herniation, requiring a left L3-4 transpedicular discectomy by, M.D. Dr. is requesting an anterior/posterior lumbar fusion with application of biomechanical device, vertebral corporectomy, lumbar laminectomy and decompression of nerve roots, posterior nonsegmental instrumentation, and allograft with a two-day length of stay.

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

The physician did not delineate in his request a level of surgical intervention or the reason for doing a 360º fusion. There is no documentation of spinal instability. There is no recurrent disc per postoperative contrast lumbar MRI. There is reference to collapse of the L3-4 disc space, which is to be expected after a discectomy, however, no documentation of instability. There is also no documentation of psychosocial screening for fusion surgery.

The preoperative surgical indications per ODG are as follows: 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 discussion and indications for discography) and MRI demonstrating this pathology. 4) Spine pathology limited to two levels. 5) Psychosocial screening with compounding issues addressed. 6) For any potential fusion, 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. All of these indications are to be met before fusion surgery is recommended. The patient in this instance does not meet several of these indications. Specifically, all pain generators have not been identified as it is not known for sure whether the L3-4 disc level is the level that is painful, since there is no documentation that the L3-4 level is the pain generator. 1) The postoperative MRI does not reveal a recurrent disc or significant compression of the L3 or L4 nerve roots. 2) There are no x-rays or records indicating instability. 3) Psychosocial screening to address compounding issues is not documented in the medical records.

Additionally and significantly, the study cited in ODG found that in cases of worker's compensation, patient outcomes related to fusion may have other compounding variables that may affect overall success of the procedure which should be considered. Until further research is conducted, there remains insufficient evidence to recommend a fusion for chronic low back pain in the absence of stenosis and unstable spondylolisthesis, and this treatment for this condition remains under study. The study also noted that it appears that worker's compensation populations require a particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in some groups of patients who are receiving compensation or involved in litigation. Despite poorer outcomes in worker's compensation patients, utilization is much higher in this population than in group health. Pre-surgical biopsychosocial variables predict patient outcomes from lumbar fusion which may help improve patient selection. The worker's compensation status, smoking, depression, and litigation, were the most consistent pre-surgical predictors of poorer patient outcomes. Other predictors of poor results were a number of prior low back operations, low household income, and older age.

Therefore, based upon the above rationale and the cited peer reviewed guidelines, the request for a 360º lumbar fusion is not certified.

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)**