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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/20/09

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an anterior lumbar fusion at L4-5 and L5-S1 with posterior fusion at L4-S1 and left laminotomy at L4-S1 with 3 day LOS.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years and performs this type of service in daily practice.

**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 an anterior lumbar fusion at L4-5 and L5-S1 with posterior fusion at L4-S1 and left laminotomy at L4-S1 with 3 day LOS.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

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**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male with an injury of back on xx/xx/xx. Previous lumbar surgeries include Laminectomy/discectomy L5/S1 in 1985 and Laminectomy/discectomy L4/5 in 1992 and revision 1997. The only physical exam recorded 08/06/09 by Dr MD (the requesting surgeon) records normal motor, sensory, and reflex examinations. A 2/16/2006 EMG by MD noted left L4, L5 and S1 radiculopathy (sic). Discography shows pain with L5/S1 disc injection and a leaking L4/5 disc. MRI shows L4/5 HNP on the left. Request is made for L4/5 and L5/S1 360° fusion and Laminectomy L4-S1.

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

Diagnosis of radiculopathy requires clinical objective findings of nerve dysfunction. Without diagnosis of radiculopathy, repeat laminectomy is not indicated for HNP at L4/5; therefore, fusion is not indicated for third discectomy, or additional level fusion with symptomatic discogram.

The most important clinical components required to support the diagnosis of a compressive Radiculopathy include: Associated clinical findings such as loss of relevant reflexes, muscle weakness and/or atrophy of appropriate muscle groups, loss of sensation in the corresponding dermatome(s). Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy. Therefore the diagnosis of radiculopathy by ODG and the AMA Guides to the Evaluation of Permanent Impairment are not met as the patient's neurologic exam is normal.

Indications for spinal fusion may include: 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.

ODG Indications for Surgery -- Discectomy/laminectomy --

Required symptoms/findings: Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present

**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 KNOWLEDGBASE

- 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)**