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Notice of Independent Review Decision

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a lumbar 360 L5/S1 fusion, iliac graft and lumbosacral orthotic brace.

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.

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 the prospective medical necessity of a lumbar 360 L5/S1 fusion, iliac graft and lumbosacral orthotic brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 11/17/10 review response by MD, 10/14/10 denial letter, 10/11/10 report by MD, 10/7/10 preauth request, 10/29/10 denial letter, 10/22/10 report by MD, 10/21/10 letter by 10/29/10 letter by RN, 10/29/10 letter by, 7/28/10 report by DO, 7/23/10 preauth request, 2/5/10

preauth request, 12/18/09 report by MD, 12/4/09 brain MRI report, 12/3/09 cervical MRI report, 1/6/06 lumbar MRI report, 11/12/09 lumbar MRI report, 2/25/10 lumbar myelogram report, 2/25/10 lumbar CT myelogram report, 2/25/10 operative report, 3/17/08 to 6/16/08 reports by MD, 4/4/08 to 5/7/08 handwritten reports by Clinic, 4/4/08 to 5/7/08 procedure notes, 10/23/09 to 2/4/10 reports by Dr. 12/15/09 to 9/28/10 reports by PA and 2/9/10 report by DO,

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has a history of a fall with subsequent back pain that has persisted. An 11/12/09 dated lumbar MRI has revealed a central disc protrusion at L5-S1, and degenerative disc disease without apparent encroachment on the spinal cord or nerve roots. A 2/25/10 dated CT-myelogram has revealed mild degenerative disc disease and neuroforaminal narrowing at both L4-5 and L5-S1. Denial letters have provided rationale of the lack of segmental instability on imaging studies, along with the lack of a documented psychosocial screen (with potentially confounding issues addressed). On 9/28/10, Attending Physician records revealed that the claimant had no apparent neurologic abnormalities related to motor power, sensation or reflexes. The claimant is status post treatment with medications, epidural steroid injections and pain management. The claimant's 10/21/10 dated appeal letter referenced that she was in "pain 24 hours a day "and depression."

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

Without clinical and radiographic evidence of segmental instability (at the segment being considered for a circumstantial fusion) applicable ODG criteria has not been evidenced. ODG criteria includes that segmental instability must be evident. Imaging studies have not been provided that evidence such instability. In addition, there has not been a psychosocial screen report submitted denoting that this individual has had a resolution of any potential confounding issues. Therefore, neither a fusion, associated bone graft and/nor back brace is medically necessary at this time, based on the applicable guidelines.

Reference: ODG-Lumbar Spine 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).] (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).] (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.

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.

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)**