



Notice of Independent Review Decision

DATE OF REVIEW: 7/9/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 360 fusion L3-4 and L4-5 with 2 day inpatient stay – CPT codes 07637, 95920 and 22630.

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

Texas licensed 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)

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 previously denied request for 360 fusion L3-4 and L4-5 with 2 day inpatient stay – CPT codes 07637, 95920 and 22630.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Reconsideration Request Letter dated 6/15/10.
- Request Letter dated 6/7/07.
- Follow Up dated 6/24/10, 3/15/10, 2/2/10, 11/24/09, 10/26/09, 10/14/09, 10/5/09.
- Evaluation dated 6/1/10.
- Surgery Scheduling Slip/ Checklist dated 2/11/10.
- Electrodiagnostic Medicine Consultation dated 1/29/10.
- Electrodiagnostic Studies dated 1/29/10.
- Lumbar Discogram and CT dated 1/26/10.
- Behavioral Medicine Evaluation Report dated 12/14/09.
- Operative Report dated 11/5/09.
- Patient Information dated 10/5/09, 9/21/09.
- Radiology Report dated 9/01/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Reaching out across his body while lifting things.

Diagnosis: Diskogenic syndrome.

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

This male was injured on xx/xx/xx, when he reached across his body while lifting things. He felt immediate pain in the back and bilateral lower extremities. According to the available medical records, the patient has had conservative treatments including epidural steroid injections with failure to respond. The MRI studies revealed L3-4 and L4-5 spondylosis and degeneration. A diskography noted L4-5 concordant pain and partially concordant L3-4 pain, with morphologic changes. The pain at the L3-4 level was slightly different from the usual pain but did include a component of the usual. The L4-5 level was normal in the diskography. Dr. diagnosed diskogenic syndrome. The patient had a psychological evaluation and was cleared for surgery. Electrodiagnostic studies, on January 29, 2010, indicated findings consistent with a distal sensory and motor polyneuropathy with external layers and demyelinating features. There were no findings that noted coexistence right or left lumbosacral acute radiculopathy at L3 to S1. The prior peer review recommended non-certification of the 360 fusion at L3-4 and L4-5, noting that there was no evidence of spinal instability and no documentation of nerve root compromise on imaging studies. The physical examination did not note any neurological deficits as there were normal motor, sensory, and reflex findings. Straight leg raising reproduced pain only on the left side. On June 24, 2010, in follow-up, Dr. indicated that surgery

was denied due to lack of evidence of spinal instability and imaging studies, no documentation of nerve root compression, no evidence of neural deficits with normal motor, sensory, and reflex on examination. Dr. indicated that the patient had significant low back pain, radicular symptoms down both the right and left lower extremities with the back pain at 6/10 and leg pain at 5/10. Objectively, he noted that the patient had limited range of motion secondary to pain, especially in flexion. He had complaints of low back pain radiating to the buttocks. Straight leg raise testing did not identify which leg was tested. Reflexes and sensations were unchanged. He did indicate that the patient had participated in preoperative rehabilitation, which was unsuccessful. The patient had spondylosis and degeneration on MRI at L3-4 and L4-5. Diskography was positive at L4-5 with concordant pain and partially concordant at L3-4. The current clinical information provided for review did not support the requested procedure. This reviewer agrees with the prior peer review that there was no documentation of spinal instability necessitating fusion. Medical literature does not support lumbar fusion for positive diskography alone. There is no evidence of spinal segment collapse as required by ODG and therefore, the previous adverse determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
 - Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Low Back Chapter, Lumbar Fusion
 - Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated

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](#)," after 6 months of conservative care. For workers' comp populations, see also the heading, "[Lumbar fusion in workers' comp patients](#)." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended [conservative therapy](#). [For spinal instability criteria, see AMA Guides ([Andersson, 2000](#))] For complete references, see separate document with all studies focusing on [Fusion \(spinal\)](#). There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).