

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed anterior/posterior Lumbar fusion at L4-S1 with instrumentation and bone graft, 3 day LOS (22612, 22614, 22840, 22842, 20938, 22558, 22585, 38230, 22851)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	22612		Prosp	1					Upheld
721.42	22614		Prosp	1					Upheld
722.52	22840		Prosp	1					Upheld
722.52	22842		Prosp	1					Upheld
722.52	20938		Prosp	1					Upheld
722.52	22558		Prosp	1					Upheld
722.52	22585		Prosp	1					Upheld
722.52	38230		Prosp	1					Upheld
722.52	22851		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 30 pages of records received to include but not limited to:
TDI letter 6.17.10; letter 5.17.10, 6.9.10; records. Dr. 2.25.10-5.4.10; Lumbar Meylogram 9.4.09;
post Meylogram CT 9.4.2009; MRI L-spine 6.2.09;
Requestor records- a total of 15 pages of records received to include but not limited to:
records. Dr. 2.25.10-5.4.10; Lumbar Meylogram 9.4.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the letter of non-certification dated May 12, 2010. Dr. noted that there was a disc lesion at L4-5, with no evidence of a compression fracture. A CT myelogram noted the disc lesion, a spondylitic disc bulge and foraminal stenosis and facet arthrosis.

A reconsideration was completed by Dr. who also that the provisions within the ODG for a lumbar fusion were not met.

The first progress note from the requesting provider was dated February 25, 2010. Dr. noted that the injured employee was referred from Dr. with complaints of back and bilateral lower extremity pain. The reported mechanism of injury was a lifting event. Physical therapy was completed, as was a pain management consultation. There was no bowel or bladder dysfunction noted.

The injured employee is noted to be 6'2", 234 pounds and hypertensive. There was a decreased range of motion to the lumbar spine and a loss of sensation in all lumbar dermatomes. Straight leg raising was reported as positive. MRI studies noted degenerative disc disease and facet hypertrophy. Myelogram noted a L4-5 defect.

At follow-up injections and a suggestion for discogram was made. The May 25, 2010 note refers to the non-certification of the proposed fusion surgery. It was noted that the injections were effective for approximately one week. A portion of the ODG standards for fusion surgery were cited, however, Dr. left out the rest of the requirements.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines 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. ([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.

(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

There is no defect, fracture, infection or instability (or excessive motion) objectified in the progress notes presented for review. Thus, the standards for a two level anterior/posterior fusion are not met and the determination of the prior reviewers is upheld.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES