



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 5/24/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an interop nerve test add-on, removal of vertebral body, remove vertebral body add-on, lumbar spine fusion, additional spinal fusion, apply spine prosth device, and sp bone algrft add-on (95920, 63090, 63091, 22558, 22585, 22851, 20931).

**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. This reviewer has been in active practice for greater than 10 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 an interop nerve test add-on, removal of vertebral body, remove vertebral body add-on, lumbar spine fusion, additional spinal fusion, apply spine prosth device, and sp bone algrft add-on (95920, 63090, 63091, 22558, 22585, 22851, 20931).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
MD and Services

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: B. MD Follow-up Notes – 6/26/09-1/4/10, Consultation notes – 6/3/09; Sys Radiology reports – 8/25/09-3/26/10, Operative Report – 8/25/09; Hospital MRI Cervical Spine Report – 6/23/09.

Records reviewed from Services: Inst Pre-auth Request – 3/25/10, Surgery Scheduling Slip/Checklist – 3/9/10, Injured Worker Information – undated, Patient Profile – 3/9/10, Consultation report – 3/9/10, Radiology Report – 3/9/10, Reconsideration Request – 4/6/10; Hospital MR Lumbar & Spine Report – 6/23/09; MRI report – 5/13/08; MD Exam Findings Report – 2/15/10; DO EMG/NCS report – 6/25/08; Various TWCC73s; Eval report – 2/19/10; MD Peer to Peer report – 3/30/10; Specialty Services Denial Letter – 3/30/10 & 4/13/10; MD review report – 4/13/10; TWCC1 – 4/10/08; DWC69 – 4/14/10; DC Impairment Rating Eval – 4/14/10, Exam Findings Report – 5/23/08, 10/7/09, & 1/5/10; Healthcare PPE report – 4/9/10; MD History & Physical report – 5/27/08.

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

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured in a work related injury on or about xx/xx/xx has been noted to have been previously injured in a T bone motor vehicle accident. The claimant continues with low back and right leg pain. Decreased sensation in multiple lumbar nerve root distribution with weak iliopsoas and bilateral EHL and tibialis anterior were noted on 1/4/10. The MRI has been noted to reveal HNP, nerve root compression at L3-L4 and L4-5. Lumbar laminectomy and fusion were felt to be medically indicated. Denial letters dated 3/30/10 and 4/13/10 indicate the absence of instability and electrical evidence of radiculopathy.

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

Without flexion-extension films documenting instability, a psychosocial clearance and/or electrodiagnostics supporting specific radiculopathy levels, the entirety of the (multi-level) consideration for both decompression and fusion does not appear to be reasonably required at this time, based on applicable guidelines.

Reference: ODG 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. [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 & 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)