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**Notice of Independent Review Decision**

**AMENDED REPORT 5/25/2010**

**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 insertion of spine fixation device and prosthetic implant device (CPT 22840 & 22851).

**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 in this field.

**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 disagrees with the previous adverse determination regarding the prospective medical necessity of an insertion of spine fixation device and prosthetic implant device (CPT 22840 & 22851).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Neurosurgical Assoc., MD, and Services

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from Neurosurgical Assoc: Office Notes – 2/18/10-5/3/10, Clinical & Patient Info – 2/4/10; MD Diagnostic Radiology report – 2/18/10; Hospital MRI Report – 11/10/09, Operative Report – 9/9/09 & 9/29/09, Radiology Report – 9/16/09, Surgical Pathology Report – 9/9/09; WIDE Open MRI report – 12/2/08; Clinic report – 11/11/08(x2); Services Approval letter – 12/11/08 & 11/30/09, Pre-auth request – 11/23/09 & 1/5/10, Denial letter – 1/8/10;. Med. Ctr Radiology report – 5/18/09; MD EMG/NCS report – 12/16/09; MCMC IRO Decision – 2/1/10; G.P. Foox, MD RME report – 5/6/09, Impairment Rating Report – 1/19/10; MD Office Notes – 11/11/08-12/31/09; Medical & Surgical Assoc. Medical Necessity letter, Fax Cover Sheet, & WC Pre-Auth Request – 12/9/08, and office Notes – 12/15/08-1/9/09.  
Records reviewed from MD: Office Notes – 5/18/09 & 11/20/09.  
Records reviewed from Services: Denial letters – 4/12/10 & 4/23/10, Approval Letter – 4/29/10; Neurosurgical Assoc. Pre-auth Request - 4/7/10, Reconsideration Request – 4/23/10; MD report – 4/12/10, and MD report – 4/29/10.

A copy of the ODG was provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The diabetic with a “tractor moving” associated injury was noted to have low back pain with radiation along with subjective leg weakness. Exam findings have included grade 4/5 lower extremity motor power. The 12/16/09 dated electrodiagnostic study revealed sciatic neuropathy without evidence of lumbar radiculopathy. On 2/18/10, the Attending Physician denoted that flexion-extension films revealed an increase in spondylolisthesis and that a decompression and at least an L4-5 fusion were indicated. A radiologist report from 2/18/10 (and also 5/18/10) denoted “no abnormal shifting” of the vertebrae during flexion and extension films, along with facet arthropathy.

The denial letter of 4/12/10 was noted to include the lack of documented instability and/or evidence of a psychosocial screen. The 4/29/10 dated letter revealed a consideration for fusion without instrumentation. A 12/2/08 dated MRI revealed spinal stenosis at multiple levels.

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

Applicable guidelines would support a procedure of such magnitude as proposed. The increase in spondylolisthesis in the already approved fusion reasonably support “instability” as a clinically significant diagnosis. Although the claimant is clearly at a significant increased risk of post-op complications (due to comorbidities including diabetes) that fact does not preclude the medical necessity of increased stabilization and probability of fusion associated with both the fixation and prosthetic implant devices. The procedure is medically necessary.

Reference: ODG Guidelines

Patient Selection Criteria for Lumbar Spinal Fusion:

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)