

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 3, 2010

**IRO CASE #:**

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

Medical necessity of proposed surgery –ALIF, L5-S1 with 2 day LOS (22630, 99222)

**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, 724.4	22630, 99222		Prosp	1					Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 37 pages of records received to include but not limited to: TDI letter 4.12.10; IRO request for an IRO; SRS letter 3.8.10, 3.26.10; records, Dr. 2.26.10; Neuro Diagnostic NCV study 2.5.10; MRI L-spine 2.2.10

Treating provider records- a total of 5 pages of records received from Dr. to include but not limited to: TDI letter 4.12.10; EMG/NCV study 6.2.2008; MRI L spine 4.3.08

Requestor records- a total of 22 pages of records received from Dr. to include but not limited to: PHMO Notice of an IRO; records, Dr. 2.26.10; Review of Medical History & Physical exam

5.19.2009; Neuro Diagnostic NCV study 2.5.10; MRI L-spine 2.2.10;xxxxxx  
5.15.09; Positive Outlook Counseling evaluation 4.28.2009; SRS letter 3.26.10, 3.8.10

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

The medical records presented for review include a June 2, 2008 electrodiagnostic assessment completed by Dr.. This study noted that on physical examination there was a slight decrease to strength in the ankle and a sensory loss in the left L5 distribution. The study itself did not support the conclusion offered by Dr..

MRI noted circumferential disc bulging at multiple levels and facet hypertrophy at multiple levels. Foraminal stenosis was also reported.

The progress notes from Dr. begin with the February 26, 2010 note indicating a workplace injury dating back to 2008, no prior spinal surgery, the MRI changes listed above, discography from April 2009 and a psychological evaluation, also from April 2009. Dr. has performed epidural steroid injections and supervised physical therapy.

Sleep and sexual function are reportedly compromised secondary to the lumbar spine changes. Based on the physical examination that reports a decrease in lumbar spine motion, Dr. suggest an anterior lumbar interbody fusion based on complaints of pain and a positive discogram at the L5-S1 interspace.

A repeat EMG noted radiculopathy at the L3/4 level and the L5/S1 level. Repeat MRI noted a disc lesion at the L4-5 level and desiccation at the L5-S1 level.

The initial request and reconsideration noted no instability, fracture or signs of infection.

### **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 this would not be supported. The criteria for a lumbar fusion as noted in the ODG are

#### **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. ([Andersson, 2000](#))]

(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.

Thus, none of the required criteria for such an operation are met.

The electrodiagnostic assessment noted changes at the L3-4 level and the request is for a L5-S1 procedure. Further, there is no competent, objective and independently confirmable medical evidence presented that there are any changes at any levels that would be supported by the Division mandated Official Disability Guidelines for such a procedure.

Therefore, given the reported mechanism of injury, the noted and extensive pre-existing ordinary disease of life maladies and the most current imaging studies and physical examination this procedure is not supported.

**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