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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/11/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an inpatient L5/S1 laminectomy discectomy arthrodesis, cages and instrumentation.

**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 practicing 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 inpatient L5/S1 laminectomy discectomy arthrodesis, cages and instrumentation.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: Dr.

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from Dr.: 10/22/10 adverse determination letter, 10/7/10 denial letter, surgery codes page, 9/28/10 new patient consult report, 9/27/10 MRI review report, 12/1/09

lumbar x-ray report, 12/10/09 lumbar MRI report, electrodiagnostic report 1/13/10, initial report by MD and 7/2/10 to 7/15/10 follow up reports by Dr..

: 10/29/10 letter by, ODG re: spinal fusion, 12/4/09 to 9/9/10 follow up reports by Dr., 12/14/09 to 7/21/10 follow up evals by, DC, 5/18/10 to 7/6/10 reports by, MD, 6/24/10 to 6/30/10 reports by, MD, FCE report 6/1/10 and 11/2/09 report by MD and 11/17/09 to 1/13/10 PLN reports.

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

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

The claimant was injured while pulling a sofa bed. She felt sharp pain in the lower back area with radiation to both hips/legs. Exam findings revealed positive sciatic notch tenderness bilaterally, a positive left-sided Lasague's at 45 degrees, decreased left-sided knee and ankle reflexes, (subjective) paresthesias in the left L5 and S1 nerve root distribution and weakness of the left gastrocnemius. Diagnoses included multi-level disc herniations, as per the AP. MRI of the lumbar spine dated 12/10/2009 revealed a L4-5 broad-based disc protrusion with annular tear and facet hypertrophy. L5-S1 shows a central disc protrusion with tear. There was a gibbous deformity due to old anterior wedge compression fracture at L1. Electrodiagnostics from 01/13/2010 were unremarkable. The claimant is noted to have failed conservative treatment including exercises, medication, chiropractic and epidural steroid injections. Denial letters relate the lack of instability and psychosocial screen, -EMG/NCV and positive smoking history.

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

Typical ODG-associated fusion criteria have not been fulfilled. A psychosocial screen has not been documented. The claimant has a smoking history which may adversely affect a potential for fusion. Segmental instability has not been documented on a radiologist's report of lateral flexion-extension films. Spinal fusion is therefore not reasonably required at this time, based on the preceding rationale.

According to the ODG the Patient Selection Criteria for Lumbar Spinal Fusion is as follows: 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)**