



Specialty Independent Review Organization  
**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/10/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 3 day LOS for anterior lumbar interbody fusion and posteriolateral fusion of the lumbar spine at L2-3 and L3-4.

**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.

**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 prospective medical necessity of 3 day LOS for anterior lumbar interbody fusion and posteriolateral fusion of the lumbar spine at L2-3 and L3-4.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Orthopedics and

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from Orthopedics: Surgery Reservation Sheet – 7/15/10, X-ray Results – 7/20/05-8/18/09, Operative Report – 11/22/06, Office Notes – 12/3/02-8/12/10, Letter – 9/10/03, 8/23/07, 12/17/07, & 7/9/10; Denial Letter – 8/11/10, Approval Letter – 7/19/10 & 12/17/09; Spine-Volume 34 Issue 10; Spine-2002 Aug 1; 27(15): 1680-6; Eur Spine J-2003 Dec; 12(6): 567-75; Spine, 1999 Oct 1; 24(19): 2042-5; Spine J. 2001 May- Jun; 1(3): 215-24; Spine J. 2005 March; 30(6): 675-81; MD Operative Report – 9/24/03, 3/8/04, & 3/24/04; MD Post-Myelogram CT report – 8/3/10; DO Operative Report – 8/3/10; Diagnostics CMT & ROM report – 7/20/05-6/8/10; MD MRI report – 1/5/10; MD MRI report – 3/8/09; BHI2 report – 2/7/08; MD CT report – 11/22/06; MD Electro-Diagnostic Interpretation – 5/22/06; DC X-ray Report – 3/4/05, Initial Exam report – 3/4/05; Orthopedics CMT & ROM report – 2/15/05; Denial Letter – 11/10/03, Approval letter – 12/29/04; MD NCS/EMG report – 10/16/03; MD MRI report – 1/18/03; MD EMG report – 1/11/03; MD Surgery Clearance – 7/19/10; Laboratory Corp. Lab results – 7/17/10; MD Progress Note – 1/11/10-3/30/10; TDI Contested Hearing Case report – 11/17/08; I-Decisions IRO report –

12/17/07; Med letter – 9/7/07; IRO report – 2/26/07; LPt PPE report – 5/10/04, 11/22/04, & 2/24/05; TWCC69 – 1/8/03, 11/11/03, & 2/1/06; MD report – 2/1/05; LMSW letter – 1/3/05, Psychotherapy report – 11/30/04; MA report – 11/29/04; PhD Psych Eval report – 4/13/04; MD Follow-up Note – 4/1/04; MD Follow-up Notes – 9/11/03-1/29/04, Initial Comprehensive Eval Report – 8/21/03; MD DDE report – 11/11/03; MD DDE Report – 1/8/03; of TX Visit Summary – 11/27/02; Incident Report – 11/9/02; Hospital Patient Care slip – 11/10/02.

Records reviewed from: , MD letter – 8/26/10, Pre-auth Review report – 3/11/09, 12/16/09, 7/15/10, 8/6/10, & 8/17/10, Denial Letter – 8/23/10; IRO Response letter – 2/2/07, Denial letter – 1/5/07 & 3/16/09; email – 8/23/07; emails – 3/12/09-3/13/09, Reconsideration report – 10/17/07-7/19/10.

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

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

The patient has been considered for an anterior and posterior L2-4 fusion. Denial letters reflected the lack of documented mechanical instability. AP records reflect clinical findings including the lifting (client co-transferring) mechanism of injury, the patient's subjective low back pain and normal neurological exam. Imaging studies have most recently included the 8/3/10 dated CT-myelogram reflecting degenerative changes. A 1/5/10 dated MRI revealed similar findings. Conservative treatment including medications, injections and therapy have reportedly failed, as per a review of AP records. A psychosocial screen was not problematic.

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

The reviewer states that without (flexion-extension) imaging studies documenting evidence of mechanical instability at the proposed fusion levels, the proposed combination procedures (and hospitalization) are therefore not reasonably required at this time, as per applicable guideline criteria.

### **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). ([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. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). ([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. (See [ODG Indications for Surgery -- Discectomy.](#))

**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. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

**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 KNOWLEDGBASE
- 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)