



3250 W. Pleasant Run Road Suite 125 Lancaster, TX 75146
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 02/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an inpatient TLIF at L5-S1 decompression with LOS of 3 days (22612, 63047, 22630, 22842, 20936, 20931 77) and a post-operative DME stimulator/brace (E0748, L0631).

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 TLIF at L5-S1 decompression with LOS of 3 days (22612, 63047, 22630, 22842, 20936, 20931 77) and a post-operative DME stimulator/brace (E0748, L0631).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from MD: Denial Letters – 1/21/11 & 2/3/11; MD Surgery Script – 12/28/10, Appeal Request – 1/27/11, Addendum report – 1/27/11, History & Physical – 12/7/10; Follow-up Exam note – 12/28/10, WC Verification – 12/7/10; MD MRI Lumbar spine – 12/28/10; MD MRI L-spine – 5/27/08; MD MRI L-spine – 9/5/06; PhD Psychology Initial Eval report – 2/12/09; Specialists, PA fax cover – 1/6/11; various DWC73; PA-C Return Office Visit Notes – 6/22/10-10/27/10; MD Follow-up Visit note – 5/8/10, New Patient History & Physical Exam note – 12/10/09; and PA-C Return Office Visit Note – 2/11/10.

Records reviewed from: , PA-C Return Office Visit note – 11/30/10, Procedure Notes – 8/26/10 -10/27/10, Case Management Note – 6/27/10; and ODG Low Back-Lumbar and Thoracic chapter – Fusion, Discectomy/laminectomy, Bone Growth Stimulators, and Back Brace/post-operative (fusion).

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has had ongoing low back pain with decreased left leg sensation. On a xx/xx dated MRI, the claimant has had significant collapse and desiccation at L5-S1, along with facet hypertrophy and neural foraminal narrowing and annular fissures. A 12/7/10 dated progress note from the AP noted that the claimant had undergone a prior IDET procedure. The claimant has been treated with meds., therapy and ESIs, in addition to the IDET. L5-S1 disc space collapse and S1 radiculopathy was noted as per the AP. + slr and decreased sensation was noted in the left leg. Slight motion and listhesis was noted (on flexion-extension xrays) at L3-4, however there was no significant instability at the proposed segment for fusion, L5-S1.

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

The applicable ODG criteria for fusion supports that there should be instability at the proposed segment. This has not been evidenced in this case. In addition, there does not appear to be evidence of a psychosocial screen prior to such an invasive procedure, also a criterion in the applicable guidelines.

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). ([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](#))

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

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)**