



**Notice of Independent Review Decision**

**IRO REVIEWER REPORT – WC (Non-Network)**

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**DATE OF REVIEW:** 11/22/11

**IRO CASE #:**

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

22612 Posterior Lumbar Fusion  
22614 Arthrodesis, posterior/posterolateral; each add  
63056 Lumbar Transpedicular approach  
63057 Decompress Spine Cord Add-on  
63042 Lumbar Laminectomy/Discectomy  
22842 Spinal Instrumentation  
22851 Application of Prosthetic Device  
20936 Autograft for Spine Surgery  
20931 Femoral Ring Bone  
63710 Graft Repair of Spine Defect

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Orthopaedic Surgery  
Certified in Evaluation of Disability and Impairment Rating -  
American Academy of Disability Evaluating Physicians

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

22612 Posterior Lumbar Fusion- UPHELD  
22614 Arthrodesis, posterior/posterolateral; each add – UPHELD  
63056 Lumbar Transpedicular approach – UPHELD  
63057 Decompress Spine Cord Add-on – UPHELD  
63042 Lumbar Laminectomy/Discectomy – UPHELD  
22842 Spinal Instrumentation – UPHELD  
22851 Application of Prosthetic Device – UPHELD  
20936 Autograft for Spine Surgery – UPHELD  
20931 Femoral Ring Bone – UPHELD  
63710 Graft Repair of Spine Defect – UPHELD

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Electrodiagnostic Studies, 11/08/06
- Lumbar Spine MRI, 11/09/06
- H&P for Lumbar Discogram, 04/04/08
- Three Level Lumbar Discogram, 04/04/08
- Post-Discogram CT of Lumbar Spine, 04/04/08
- Lumbar Spine MRI, 08/15/08
- Evaluation, 09/10/09
- Pre-Authorization Determination Letter, 02/05/10
- Office Note, 07/28/11, 09/06/11
- Lumbar Spine MRI, 08/12/11
- Pre-Surgical Psychological Evaluation Summary, 08/17/11
- Pre-Authorization Request, 09/15/11
- Adverse Determination Letter, 09/23/11, 10/24/11
- The ODG Guidelines were not provided by the carrier or the URA.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The EMG demonstrated radiculopathy. The MRI showed disc degeneration with bilateral foraminal narrowing at L4-L5, and only disc bulging at L5-S1. These were not indications for fusion. The discography showed 10/10 concordant pain at L4-L5 with significant disc narrowing and degenerative change. At L5-S1, there was severe, 9/10 concordant middle low back pain. A fusion was recommended for “internal disc disruption at L4-L5 and L5-S1” and “recurrent disc herniation at L4-L5”:

“Since he does have positive discograms at L4-L5 and L5-S1, my recommendation would be ALIFs at L4-L5 and L5-S1 and minimally invasive percutaneous screws at L4-S1 with a minimally invasive right-sided decompression of the right L5 nerve root.”

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

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, with 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. Spinal instability criteria includes 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)

The claimant does not suffer from instability. There is no spondylolisthesis. There is no fracture, infection or tumor. The success rate of fusions indicated primarily by discography is low<sup>1</sup>.

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<sup>1</sup> Carragee EJ, Lincoln T, Parmar VS, Alamin T. A gold standard evaluation of the "discogenic pain" diagnosis as determined by provocative discography. Spine (Phila Pa 1976). 2006 Aug 15;31(18):2115-23.

The request does not meet the criteria set forth from the ODG is not consistent with best medical practices.

**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)
- AMA GUIDES 5<sup>TH</sup> EDITION