**MAXIMUS Federal Services, Inc.**
**4000 IH 35 South, (8th Floor) 850Q**
**Austin, TX 78704**
**Tel: 512-800-3515 ◆ Fax: 1-877-380-6702**

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**Amended August 30, 2011**

**Notice of Independent Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** August 24, 2011

**IRO CASE #:**

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

Rush TF lumbar interbody fusion L4-5, L5-S1 with posterolateral L4-S1, posterior stabilization with screws and rods (22630, 22632, 22842, 22851 x2, 63710, 20930).

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

M.D., Board Certified in Orthopedic Surgery.

**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 requested procedure, rush TF lumbar interbody fusion L4-5, L5-S1 with posterolateral L4-S1, posterior stabilization with screws and rods (22630, 22632, 22842, 22851 x2, 63710, 20930), is not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 8/3/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/3/11.

3. Notice of Assignment of Independent Review Organization dated 8/4/11.
4. Medical records dated 6/3/11, 3/4/11, 1/4/11, 11/30/10,
5. Medical records dated 11/11/10, 10/1/10, 9/30/10, 8/31/10, 12/10/09, 12/9/09, 11/9/09, 10/26/09, 9/29/09, 9/15/09 and 8/27/09.
6. MRI of the lumbar spine with and without contrast dated 9/22/10.
7. MRI of the lumbar spine with and without contrast dated 11/4/09.
8. Lumbar spine series with flexion and extension lateral views dated 8/31/10.
9. EMG & NCV Report Neurology and Electrodiagnostic dated 11/4/10.
10 MRI of lumbar spine without contrast dated 5/11/09.
11. Occupational Therapy Eval & Physician's Certification dated 11/20/09 and 12/16/09.
12. Medical records from MD, DABPM dated 11/2/10, 9/7/10, 7/28/09, and 6/15/09.
13. Lumbar Spine Evaluation dated 9/30/09.
14. Designated Doctor Exam dated 5/3/11.
15. Medical records from Surgical Consultants dated 8/26/09
16. Medical records dated 9/28/09, 10/26/09 and 11/9/09 (provider not identified).
17. Operative Report dated 9/16/09.
18. Denial documentation.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A male patient has requested authorization for rush TF lumbar interbody fusion L4-5, L5-S1 with posterolateral L4-S1, posterior stabilization with screws and rods (22630, 22632, 22842, 22851 x2, 63710, 20930). The URA has denied this request indicating that the requested procedure is not medically necessary for treatment of the patient's back pain.

A review of the record indicates the patient sustained an on-the-job injury on xx/xx/xxxx when he fell 8 feet. An MRI of the lumbar spine performed on 5/11/09 demonstrated 8 to 9 mm L5-S1 central disc herniation with a mild left-sided predominance; significant contact of the left S1 nerve root which could cause a radiculopathy. On 9/16/09, the patient underwent microdiscectomy at left L5-S1 hemilaminectomy and L5-S1 microdiscectomy using minimally invasive approach. MRI of the lumbar spine performed on 9/22/10 showed the following: L2-3: bilateral paracentral bulge up to 2 to 3 mm; spinal canal patent at 14 mm; minimal facet arthropathy; L3-4: no significant bulge; spinal canal patent at 13 mm; no facet arthropathy or foraminal narrowing; L4-5: central and paracentral bulge up to 3 mm with annular fissure; annular fissure appears more notable than the study from November 2009; spinal canal patent at 1cm; mild facet arthropathy; parasagittal imaging shows grossly patent foramina; L5-S1: central and predominantly right paracentral bulge up to 4mm; parasagittal imaging shows mild left foraminal narrowing with under surface nerve root contact by disc material; some mild enhancement surrounding the disc suggesting granulation tissue; at least mild foraminal narrowing on the right as well related to posterior facet encroachment and bulge. Electrodiagnostic study on 11/4/10 demonstrated chronic L5-S1 radiculopathy and no acute denervation or L4-5 pathology. On 11/11/10, the patient's provider recommended a fusion at L4-5 and L5-S1 involving anterior lumbar interbody fusion at L4-5 and L5-S1 followed by a posterior stabilization.

The URA indicates the submitted documentation does not demonstrate the requested procedure is medically necessary. Specifically, the URA states the patient does not meet ODG criteria for the procedure.

At issue in this case is whether the requested procedure is medically necessary for treatment of the patient's medical condition.

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

The requested procedure, rush TF lumbar interbody fusion L4-5, L5-S1 with posterolateral L4-S1, posterior stabilization with screws and rods (22630, 22632, 22842, 22851 x2, 63710, 20930), is not medically necessary for treatment of the patient's condition. Upon review of ODG criteria (ODG, Chapter: Low Back – Lumbar and Thoracic Fusion (Spinal)) and based on medical judgment and clinical expertise in accordance with accepted standard of practice, the requested procedure is not supported in this case. This patient is status post previous spinal surgery. His MRI showed enhanced scarring. The effectiveness of the proposed procedure will be negatively impacted by the patient's scarring. Further, the patient has not undergone discogram at the L4-S1 level and thus it is not clear which level is causing the pain. All told, the patient is not an appropriate candidate for the proposed rush TF lumbar interbody fusion L4-5, L5-S1 with posterolateral L4-S1, posterior stabilization with screws and rods and therefore the requested procedure is not medically necessary.

**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)**