



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**Date notice sent to all parties:** 12/12/2012

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an anterior lumbar interbody fusion L5-S1 with 2 days LOS.

**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.

**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 anterior lumbar interbody fusion L5-S1 with 2 days LOS.

**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:

PA:

- Prior Authorization Request – 10/1/12
- Patient Information – undated
- Consultation Report – 7/19/12

Follow-up Note – 9/7/12  
LSP:  
Workers' Compensation Verification Form – 7/17/12  
LHL009 – 11/27/12  
MLA/LPC:  
Pre-Surgical Interview Behavioral Medicine Evaluation – 9/19/12  
Doctor's Professional Association:  
Initial Examination Report – 5/30/12  
PA-C:  
Progress Notes – 5/29/12, 6/19/12  
Medical Center:  
Physical Therapy Daily Notes – 4/20/12, 4/24/12  
Physical Therapy Evaluation – 4/20/12  
MD:  
Office Note – 7/18/12, 8/27/12  
Operative Report – 8/15/12  
Imaging –Center:  
Initial Evaluation – 7/27/12  
X-ray Report – 7/27/12  
Medical Center:  
Operative Report – 4/25/12  
MRI Report – 5/17/12  
CT SP Lumbar w/contrast – 5/5/12  
Lumbar Spine X-ray Report – 5/1/12  
Diagnostic Imaging:  
MRI Report – 6/29/12

Records reviewed from:

:

Denial Letter – 11/19/12

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The xx was injured in xx/xx. This was reported to be in association with some heavy lifting. Despite multiple non-operative (and a 4/25/12 dated right-sided discectomy/laminectomy operative) treatments (as per the most recent record dated 9/7/12); there has been persistent sharp throbbing low back pain with radiation into the right greater than left lower extremity. Paresthesias including numbness and tingling have been documented as has urinary incontinence. Examination findings have revealed grade 3-5 strength of the right gastrocnemius muscle. 4-5 "breakaway" strength in both the tibialis anterior and EHL muscles on the right. Reflexes were noted as 1+ at the right angle and otherwise normal. There was a positive straight leg raise on the left at 60°. Sensation was noted to reveal hypoesthesia over the distributions of both L5 and S1 on the right side.

Post-op lumbar MRIs dated 5/17/12 and 6/29/12 revealed multiple levels of disc protrusion of the lumbar spine with postsurgical changes at the prior operative level, including a "large amount of the postsurgical granulation tissue formation." A "residual or recurrent" HNP was also noted. The provider was noted to have a recurrent HNP, as per the Attending Physician. The 9/19/12 dated psychosocial screen was reviewed. Post-op. ESI and physical therapy records were also reviewed. The provider's diagnoses have included lumbar radiculopathy with recurrent HNP at L5-S1 along with mechanical-discogenic pain syndrome at L5-S1 and lumbar spondylolisthesis at L5-S1.

Denial letters indicated a lack of documented postoperative segmental instability and-or the claimant only having undergone one prior discectomy.

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

There is evidence that the claimant has a probable recurrent disc herniation at the prior operative level, L5-S1. However, there is no imaging evidence of segmental instability as per ODG criteria. In addition, the psychosocial evaluation revealed significant psychiatric abnormalities that do not appear to be resolved at present. Without full guideline criteria having been met (specifically with regards to fusion) the requested fusion procedure is not medically necessary at this time.

Reference: ODG Low Back

Patient Selection Criteria for Lumbar Spinal Fusion:

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 correlated with symptoms and exam findings; & (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)**