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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/09/12

**IRO CASE #:**

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

Anterior/posterior lumbar fusion with hardware and instrumentation at L4-L5 with a three to five day length of stay

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

Board Certified in Orthopedic Surgery  
Fellow of the American Academy of Orthopedic Surgeons

### **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.

Anterior/posterior lumbar fusion with hardware and instrumentation at L4-L5 with a three to five day length of stay - Upheld

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

Evaluations with P.A. and Dr. dated 02/17/11, 03/17/11, 05/26/11, 08/04/11, 09/15/11, 10/27/11, and 12/01/11

Lumbar MRI dated 03/01/11 and interpreted by M.D.

Request for lumbar epidural steroid injection (ESI) from Dr. dated 03/17/11

Request for ESIs from Dr. dated 05/09/11 and 05/11/11

Request for an EMG/NCV study from Dr. dated 08/04/11

Preauthorization notice from dated 10/26/11

EMG/NCV study dated 11/22/11 and interpreted by M.D.

A request for cervical facet blocks at C2-C4 dated 12/02/11 from Dr.

A request for surgery from Dr. office dated 12/02/11

Additional preauthorization notices from dated 12/07/11 and 12/15/11

Preauthorization determinations from dated 12/07/11 and 12/15/11

A notice of preauthorization determination for Dr. from dated 12/13/11

A letter addressed to xxxxxx, IRO, from with dated 12/22/11

An undated surgery request from Dr.

The Official Disability Guidelines (ODG) were not provided by the carrier or URA

## **PATIENT CLINICAL HISTORY**

On 02/17/11, Dr. diagnosed the patient with a lumbar sprain/strain, lumbar radiculitis, and chronic lumbosacral spine sprain/strain. Norco, Anaprox, and Norflex were prescribed. An MRI of the lumbar spine dated 03/01/11 revealed a 9.1 mm. right subarticular to foraminal disc protrusion at L4-L5 that produced marked right lateral recess stenosis and marked right neural foraminal narrowing. Bilateral facet arthrosis was noted at L4-L5 and L5-S1. On 03/17/11, Dr. refilled the patient's medications and recommended a lumbar epidural steroid injection (ESI). On 05/26/11, the patient continued with low back pain that radiated to the right lower extremity. Dr. again recommended ESIs. On 08/04/11, Dr. reviewed an IME dated 06/22/11 from Dr. who felt the patient was not credible on examination, which Dr. disagreed with. On 10/27/11, Dr. reexamined the patient for his low back pain and radicular symptoms. He noted according to the *ACOEM Guidelines*, an ESI was appropriate. He also noted he prescribed Glucophage for the patient, as his glucose was around 250 and he did not have a medical doctor. An EMG/NCV study dated 11/22/11 revealed right L5-S1

radiculopathy and severe diabetic peripheral neuropathy, as well as bilateral peroneal entrapment at the fibular head. On 12/01/11, Dr. again recommended an ESI and continued the patient's off duty status. On 12/07/11 and 12/15/11, Liberty Mutual provided non-certification for the requested anterior/posterior lumbar fusion with hardware and instrumentation at L4-L5 with a three to five day length of stay.

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

This patient is morbidly obese and diabetic, uncontrolled, who does not have any objective evidence of radiculopathy. He has, proven by EMG/NCV study, diabetic neuropathy. This is not something that is treatable by a surgical procedure on his lumbar spine.

Furthermore, the patient does not meet the criteria for a spinal fusion. There is no evidence of instability. There is no evidence of spondylolisthesis, spondylolysis, fracture, infection, or tumor. The patient does not meet the criteria for the ODG for lumbar spine fusion. The pain generators in fact have not been objectively determined to be in the spine, but are most likely secondary to his morbid obesity and his diabetes. Therefore, it is unlikely that a fusion would help. Further, he has not had psychological clearance as is recommended by the ODG. There is no indication at this time for a spinal surgical procedure. While the treating physician appears to have documented a positive straight leg raising sign, he does not document whether this reproduces back pain (which is a negative test) or if it duplicates radiculopathy (which would be contradictory by the absence of the radiculopathy on the EMG). He goes on to discuss an S1 radiculopathy and the disc herniation is located at L5-S1, but recommends a fusion at L4-L5. The clinical data does not match the request for a spinal fusion. These multiple reasons, based upon the ODG and the other clinical information provided, the requested anterior/posterior lumbar fusion with hardware instrumentation at L4-L5 with a three to five day length of stay is neither reasonable nor necessary. The previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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)