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Notice of Independent Review Decision

DATE OF REVIEW: 6/13/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a posterior fusion L4-S1 anterior lumbar interbody fusion L5/S1 and L4/5 with vascular surgeon with 3 day 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. The 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 a posterior fusion L4-S1 anterior lumbar interbody fusion L5/S1 and L4/5 with vascular surgeon with 3 day LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: and Medical.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 6/1/12 letter by, medical provider list for this case, C9 form from Bureau of WC, 5/15/12 denial letter, 5/23/12 denial letter. Rx history by claim, 10/24/02 lumbar MRI report, 4/23/03 lumbar MRI report, 8/31/05 lumbar MRI report, 9/2/05 abdominal x-ray report, 4/3/12 lumbar MRI report, 2/13/07 to 12/29/09 handwritten notes from Medical Clinic, handwritten office

notes from Medical 3/7/12 to 3/26/12, 3/22/12 letter by Dr., 3/26/12 spinal impairment questionnaire, 3/28/12 patient instruction sheet, 4/11/12 lab values from Laboratories, 4/4/12 glomerular filtration and lab reports, 5/4/12 report by MD, 2/24/04 TWCC 69 and report by, MD, 6/1/12 and ODG section regarding lower back.

Dr. (Family Medical): 6/1/12 letter by Dr..

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

PATIENT CLINICAL HISTORY [SUMMARY]:
This male was injured on xx/xx/xx while lifting an oil pipe. The AP and carrier records were reviewed. On 05/04/12, back pain with right leg radiation was noted. Treatment has included medication, PT, restricted activities and injections, along with a radiofrequency ablation. Exam findings included an antalgic gait with mild flexion across the hips and knees. Dysesthesias were bilaterally noted at L5, along with weakness at the EHL, left. Reflexes were diminished at the ankles and knees, along with a positive straight leg raise on the left. Magnetic Imaging studies dated 4/3/12 revealed spondylosis with retrolisthesis in the lumbosacral segment, along with a mild anterolisthesis at L4-5 (with angular instability on flexion and extension). The impression included lumbar spondylosis, and segmental instability, along with retrolisthesis at L5-S1. Denial letters included the lack of a psychosocial screen, the lack of flexion-extension film reports evidencing anterior-posterior segmental instability, a smoking history, and, the lack of recent procedures notes regarding PT and ESIs.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Applicable ODG criteria denote that a patient candidate for decompression with fusion should be a non-smoker, unlike with the AP's patient. In addition, there must typically be evidence of lateral flexion-extension x-rays evidencing 4.5 mm of anterior-posterior translation, which has not been documented in the form of a radiologist's report. In addition, a psychosocial screen and/or recent actual records of PT and injections (and response to same) have not been provided. Therefore, clinical criteria for the proposed combination of decompression-fusion procedures have not been met at this time. Therefore, the requested procedure is not medically necessary at this time.

Official Disability Guidelines-Treatment in Worker's Compensation, Online Edition Chapter: Low Back Fusion (spinal)
Not recommended for patients who have less than six months of failed recommended conservative cart unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction1 but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after

6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy.
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: (I) 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. (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 pit-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. (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 percent 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 ODO criteria.

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.

Discectomy/ laminectomy
Recommended for indications below. Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from

the acute attack than conservative management, although any positive or negative effects on the lifetime natural history of the underlying disc disease are still unclear. Unequivocal objective findings are required based on neurological examination and testing.

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)**