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Notice of Independent Review Decision

DATE OF REVIEW: 4/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of L3-4 TLIF (cpt codes 22633, 63056, 22842, 22851, 20930, 20936) 63056, 22842, 22851, 20930, 20936.

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 L3-4 TLIF (cpt codes 22633, 63056, 22842, 22851, 20930, 20936) 63056, 22842, 22851, 20930, 20936.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):
Records reviewed :

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a who was noted to have diagnoses of progressive and severe back pain, lumbar stenosis and radiculopathy, along with leg weakness. A prior note dated 3/19/2012 revealed "Depression" present. An MRI dated 9/22/2011 revealed degenerative disc disease and prior surgery at L5-S1, with stenosis at L4-5, and, stenosis with anterolisthesis, as well as an annular tear and facet arthritis at L3-4. There was "no direct root compression evident." An x-ray from 12/15/2011 reported a 1 mm increase of the 3 mm anterolisthesis with flexion. A TLIF was felt indicated by the provider, as Physical Therapy and Epidural Steroid Injections provided "no" relief. Denial letters referenced the lack of physical examination findings, conservative treatment, segmental instability and/or true radicular deficits. An appeal letter dated 3/19/2012 denoted that the patient has had severe intractable back pain with leg pain and paresthesias. Significant trigonal stenosis was noted at L3-4, with the increase in anterolisthesis in flexion. The impression was felt to be mobile spondylolisthesis with stenosis, along with severe back pain and radiculopathies.

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

Recommended denial of the requested service. There has not been documentation of recent objective neurological or other physical examination findings regarding the low back, including sensory, motor and reflex findings. Segmental instability (as per Official Disability Guidelines criteria of 4.5 mm of motion) was not evident on flexion-extension films. A psychosocial screen was not documented, nor has the actual notes evidencing PT, medications and ESI(s), along with detailed outcomes of trials. Any smoking history has not been documented, as per fusion criteria. Therefore, Official Disability Guidelines criteria have not been met at this time, rendering the requested procedures not reasonable and/or not medically necessary at this time.

Reference: Patient Selection Criteria for Lumbar Spinal Fusion:

Pre-Operative Surgical Indications Recommended: (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](#))

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)