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## Notice of Independent Review Decision

**DATE OF REVIEW:** 1/25/2013

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Arthrodesis, Posterior or Posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).

**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 disagrees with the previous adverse determination regarding the prospective medical necessity of Arthrodesis, Posterior or Posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Texas Department of Insurance and

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

Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake Paperwork

Records reviewed from

Denials- 12/6/12, 1/4/13, 1/8/13

Pre-Authorization Request- 12/6/12

Appeal- 1/8/13

Dr.

Transforaminal Thoracic/Lumbar Interbody Fusion- undated

Office Notes- 11/13/12

The Clinic

Office Notes- 11/5/12, 10/11/12

M.D.

Office Notes- 10/1/12

Neuroradiology, PA

Lumbar Spine Radiographs- 11/13/12

Hospital and Clinics

MRI Lumbar Spine w/o Contrast- 10/20/12

Radiology Services Report- 2/6/09

MRI Central

MRI of the Lumbar Spine w/o enhancement- 5/13/08

Interpreting Physicians Network

Electro-Diagnostic Interpretation- 6/13/08

Medical Examination Svcs, Inc.

Peer Review by Dr. - 5/15/09

County Healthcare Systems

Evaluation- 11/1/12

Spine Institute

Pain Diagram- undated

History- undated

Surgical History- undated

Spine and Scoliosis

Office Notes- 11/13/12

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

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The xx was noted to have sustained a low back injury while working in xx. Electrical studies dated 6/13/08 revealed mild chronic re-innervation process involving L4-S1. Treatment with medications and therapy occurred between 2006 through 2008. There was a treatment gap between 1/09 and 10/12. On 10/1/12, it was noted that the claimant had reduced ankle reflexes bilaterally along with reduced L5 dermatomal sensation. Straight leg raising was

positive bilaterally. An updated MRI was dated 10/20/12. It was noted to reveal a disc bulge at L3-4, with hypertrophic changes of the posterior elements. Disk space narrowing was noted to be severe at L4-5. An 11/1/12 dated psychosocial screen clearance was noted. On 11/13/12, the claimant was noted to have complaints of back pain with paresthesias and weakness into the lower extremities. On exam, weakness was noted in multiple muscle groups in the lower extremities. The diagnoses included significant stenosis at multiple levels of the lumbosacral spine, along with radiculopathy. Exhaustion of conservative treatment was discussed, and it was noted to not have provided "long-term relief." The severity of stenosis was noted in that (if treated with decompression alone) would result in instability. Denial letters included the lack of a preoperative psychosocial screen along with a lack of a recent comprehensive non-operative treatment protocol trial and failure.

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

Recommend approval of requested services. Applicable clinical guideline criteria supports a consideration for fusion when comprehensive non-operative treatment has been tried and failed. In this case, such documentation has been reasonably provided. In addition, guideline criteria of a psychosocial screen has now been provided. Finally, stenosis has been noted to be severe at an isolated level, and, decompression alone would likely result in instability. Therefore, overall intent of ODG criteria have been met for the request at this time.

**Reference:** ODG Lumbar Spine

Patient Selection Criteria for Lumbar Spinal Fusion:

(See [ODG Indications for Surgery -- Discectomy.](#))

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](#))

**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)