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Notice of Independent Review Decision

**February 19, 2013 Amended: February 19, 2013**

**IRO CASE #:**

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

Lumbar bone graft L5-S1 and re-evaluation and exploration of posterolateral fusion

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

Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

- Office visits (04/27/07 – 12/17/12)
- DWC-1 (04/28/07)
- Diagnostics (05/11/07 – 08/10/12)
- Procedures (06/25/07 - 11/10/10)
- Reviews (08/14/07 – 12/15/11)
- FCE (05/18/09)
- DWC-69 (07/20/09)
- IRO (08/27/09)
- Utilization reviews (10/12/09, 01/15/13, 01/25/13)

- DWC-73 (10/11/07 - 06/07/11)
- Therapy (04/19/11 – 05/13/11)

**TDI**

- Utilization reviews (01/15/13, 01/25/13)

**M.D.**

- Diagnostics (5/11/07 - 08/10/12)
- Review (08/14/07)
- Office visits (05/11/09 - 12/17/12)
- Procedure (11/10/10)
- Utilization reviews (08/08/11 - 05/01/12)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained an injury to her low back as a resulting of lifting furniture set on xx/xx/xx.

On xx/xx/xx, M.D., evaluated the patient for excruciating back pain radiating into the right thigh. On examination, there was tenderness in the lumbar area and reduced lumbar range of motion (ROM). She had a slow gait. Radiographs showed narrowing of the L5-S1 area and most probable displacement of disc. Dr. diagnosed back injury, sciatica and rule out herniated disc; injected Toradol; prescribed ibuprofen, Skelaxin and Vicodin and ordered magnetic resonance imaging (MRI).

On May 11, 2007, MRI of the lumbar spine showed: (1) Degenerative disc disease (DDD) associated with 5-mm central herniated disc at L5-S1 disc interspace and osteoarthritic changes of L5-S1. (2) Mild degenerative facet joint disease bilaterally at L5-S1.

On May 24, 2007, M.D., evaluated the patient for low back pain with radiation to the right lower extremity. X-rays of the lumbar spine showed a grade 1 lytic spondylolisthesis at L5-S1 that translated 2-3 mm on flexion and extension. Dr. reviewed the MRI findings; diagnosed back pain, sciatica and acquired spondylolisthesis and prescribed Skelaxin, Vicodin and ibuprofen. He referred the patient for pain management and possible epidural steroid injection (ESI). If the patient would fail then she should be a candidate for posterior lumbar fusion.

On June 5, 2007, M.D., evaluated the patient for sharp, throbbing and moderate low back pain radiating into the right leg and numbness and tingling off and on in the right lower extremity. Dr. diagnosed low back pain, lumbar radiculopathy and herniated nucleus pulposus (HNP). Dr. prescribed Etodolac and Darvocet N and recommended electromyography (EMG) of the lower extremities and right L5-S1 transforaminal ESI.

On June 25, 2007, the patient underwent L5-S1 transforaminal ESIs.

On August 3, 2007, EMG/NCV study showed lumbar radiculopathy involving the L5 nerve roots bilaterally, most significant in the right L5 nerve root.

On August 3, 2007, Dr. reviewed the EMG/NCV findings and prescribed Ultram and Lyrica.

On August 8, 2007, computerized tomography (CT) myelogram of the lumbar spine showed a subtle grade 1 spondylolisthesis at the L5-S1 level. Post myelogram CT scan showed a subtle spondylolisthesis of L5 on S1 of approximately 5 mm. There were considerable degenerative changes noted in the posterior facets at L5-S1 suggesting a degenerative spondylolisthesis. At L5-S1 there appeared to be a lateral disc bulge encroaching in the inferior margin of the right foraminal recess.

On August 14, 2007, D.O., performed a designated doctor evaluation (DDE) and opined that the extent of injury was limited to herniated disc at L5-S1. The DDD, degenerative facet disease and osteoarthritic changes were not a result of the injury.

From September 4, 2007, through December 11, 2007, Dr. treated the patient with Ultram, Mobic, Lyrica, etodolac and amitriptyline and transforaminal ESI x2.

On February 20, 2008, M.D., performed a required medical evaluation (RME) and opined as follows: (1) The patient sustained a soft tissue injury which was superimposed on pre-existing degenerative disease. (2) The patient had sustained an injury to the lumbar spine that was consistent with mechanism. (3) None of the objective imaging studies demonstrated any structural injury to the spine related to the occupational event. (4) The MRI and CT scan had all failed to indicate any kind of nerve root impingement of significant lateral herniation. (5) There did not appear to be any spondylosis, only degenerative spondylolisthesis. (6) The radicular type symptoms might be related to the sacroiliac (SI) conditions or piriformis tightness, particularly given the non-focal nature of the objective testings thus far. (7) Conservative treatment had been inadequate as no physical therapy (PT) had been offered. (8) The patient was fit to return to modified duties. Dr. recommended a functional capacity evaluation (FCE).

From February 29, 2008, through April 29, 2008, Dr. Canon treated the patient with etodolac, amitriptyline, Lyrica and Ultram.

On December 15, 2008, Dr. noted improvement in the patient's symptoms with rest and NSAIDs. Dr. reviewed the x-rays and MRI findings that showed grade 1 spondylolisthesis at L5-S1 with HNP and some right foraminal stenosis at that level. He diagnosed L5-S1 spondylolisthesis and herniated disc, prescribed durable medical equipment (DME) and recommended bilateral laminectomy at L5-S1 level and posterior lumbar spinal fusion and interbody cage at L5-S1 level.

**2009 – 2010:** From January 16, 2009 through February 17, 2009, Dr. treated the patient with etodolac, amitriptyline, Ultram and Lyrica.

On May 11, 2009, x-rays of the lumbar spine showed instability at the L5-S1 level.

On May 11, 2009, Dr. evaluated the patient for ongoing complaints in the low back. The patient had undergone six epidural injections which helped her for her leg symptoms. She complained of lumbar pain with radiation down to the right leg and her right leg gave out on her. Dr. reviewed the CT scan and EMG findings and diagnosed grade 1 spondylolisthesis at L5-S1. He prescribed tramadol, Lorcet, Feldene, Zanaflex and Ambien and ordered a functional capacity evaluation (FCE) to determine the patient functional limitations.

Per FCE dated May 18, 2009, the patient performed at a medium physical demand level (PDL) versus medium PDL required for her job.

Per impairment evaluation dated May 27, 2009, the patient was awarded 13% whole person impairment (WPI) rating. The report is incomplete.

On June 3, 2009, Dr. diagnosed spondylolisthesis at L5-S1 with instability and right L5 radiculopathy and opined that the patient had reached statutory maximum medical improvement (MMI) as of May 2, 2009. This report is incomplete.

On July 16, 2009, Dr. evaluated the patient for lumbar pain radiating into the lower extremities bilaterally and burning sensation in right lower extremity down to the foot. Dr. recommended a fusion at L5-S1 to address L5 radiculopathy on the right side and renewed medications. He recommended completing psychosocial screening and CT myelogram films.

On July 20, 2009, M.D., performed a designated doctor evaluation (DDE) and opined that the patient had reached statutory MMI as of May 1, 2009, with 10% WPI rating.

Per Independent Review Organization (IRO) dated August 28, 2009, the denial for BHI-2 psychosocial screening/testing was overturned.

On September 28, 2009, Dr. recommended that the patient was a surgical candidate for a fusion at L5-S1 to address L5 radiculopathy on the right. He recommended a discogram prior to proceeding with a fusion. The patient was also prescribed a muscle stimulator.

On September 28, 2009, the patient underwent a psychological evaluation.

On October 2, 2009, Dr. reviewed a DDE prepared by Dr. dated July 20, 2009. He agreed with the statutory date of MMI as May 1, 2009; however, he disagreed with calculation of impairment. The calculation of impairment that he believed was corrected was outlined in the DWC-69 that he prepared in June 2009.

On October 5, 2009, MRI of the lumbar spine showed the following findings: (1) There were changes of prior left L3-L4 laminotomy. Subtle epidural fibrosis in the region of the left L3-L4 lateral recess was noted. Enhancement along the dorsal aspect of the L3-L4 disc was related to granulation tissue from prior surgery. The right lateral recess was mildly encroached secondary to spondylosis and annular disc bulging at the L3-L4 level. No central canal stenosis at L3-L4 was seen. The right L3-L4 neural foramen was mildly encroached. (2) There was moderate central canal and right Lateral recess stenosis at L4-L5 secondary to spondylosis and annular disc bulging superimposed on a broad-based right foraminal disc-osteophyte complex. Epidural lipomatosis, bilateral ligamentum flavum hypertrophy and bilateral facet osteoarthritis at L4-L5 were also seen. The right L4-L5 neural foramen showed moderate-to-severe encroachment. The exiting right L4 nerve root sheath was contacted. There was mild left L4-L5 neural foraminal narrowing. (3) There was mild canal, bilateral lateral recess, and bilateral neural foraminal encroachment at L2-L3 secondary to spondylosis and annular disc bulging. The report is incomplete.

On October 9, 2009, Dr. requested pre-authorization for low pressure lumbar discogram with post CT. However, the request was denied.

On December 7, 2009, Dr. prescribed treatment with an NMES (neuromuscular stimulator) unit for 30 days.

On December 11, 2009, Dr. noted that the request for discogram was improperly submitted through voluntary certification and although no official review was done, it was denied based on an extent of injury dispute. When the extent of injury dispute was resolved, a second attempt at voluntary certification was not allowed; however, voluntary certification was appropriate type of certification for this healthcare service. Examination showed lumbar tenderness with some decreased and painful ROM. The patient continued to have a diminished sensation along the right L5 along the lateral aspect of her leg.

**2010:** On January 28, 2010, Dr. requested preauthorization for anterior and posterior discectomy and fusion at L3-L4 and L4-L5.

In February and April, Dr. noted that request for a pre-operative lumbar discogram was denied by the patient's insurance carrier. The patient continued to have low back pain with occasional radiating pain down her right lower extremity with numbness and tingling present from time to time. Examination of the lumbar spine showed continuous tenderness in the lower lumbar region and decreased ROM with flexion and extension limited by pain. There was diminished sensation along her right L5 distribution and along the lateral aspect of her leg. She was able to walk on toes and walk on heels with some discomfort in her low back area. Diagnosis was collapse at L5-S1 with neurogenic claudication of L5 and mechanical back pain. Dr. Berliner recommended submitting an IRO for lumbar discogram. He renewed medications which were necessary to treat the symptoms naturally resulting from the compensable injury.

On July 29, 2010, Dr. noted that the patient continued to have 7/10 lumbar pain that was worse with prolonged standing and the pain radiated into her leg and down to her right foot occasionally. Dr. reviewed diagnostic studies. MRI of the lumbar spine revealed bulging at L5-S1 with right far lateral foraminal stenosis. X-rays of the lumbar spine including flexion and extension views were obtained on December 15, 2008, which showed 3 mm of translation between the flexion and extension views of L5-S1 then. Examination of the lumbar spine showed pain on ROM, diminished sensation along the right L5 distribution, but her extensor hallucis longus (EHL) were intact. The diagnosis was instability of the lumbar spine at L5-S1 and neurogenic claudication at L5. Dr. recommended discectomy and fusion at L5-S1.

On October 1, 2010, Dr. noted that the patient's request was pending an IRO. The plan was performing lumbar decompression and lumbar fusion. The patient's medications were renewed and she was given an electrical muscle stimulator to help control her pain and decrease her need for narcotics.

On November 3, 2010, the patient was prescribed bone grown stimulator, walker, elevated toilet seat and pain pump.

On November 10, 2010, Dr. performed anterior lumbar corpectomy, L5 with discectomy at L5-S1, anterior lumbar interbody fusion (ALIF), anterior lumbar instrumentation L5 and S1, preparation of application of interbody device, preparation of application of local bone graft harvested from the anterior corpectomy, use of intraoperative microscopic magnification and light intensification, intraoperative neuro-monitoring and Cell Saver. He also performed lumbar laminectomy at L5-S1, posterolateral fusion at L5-S1, posterior instrument at L5-S1, use of intraoperative microscopic magnification and light intensification, preparation and application of local bone graft harvested from the

laminectomy, application of external bone external stimulator, intraoperative neuro-monitoring and Cell Saver.

Postoperatively, a letter of medical necessity was provided for a bone growth stimulator.

On November 13, 2010, the patient was discharged. The hospital course was as follows: The patient was admitted and underwent an uncomplicated lumbar fusion on November 10, 2010. Postoperatively, the patient's hemoglobin and hematocrits stabilized. She advanced to a regular diet. She was discharged to home in stable condition on November 13, 2010. She was instructed to wear a back brace and follow-up with Dr. at proximately a week after discharge.

On November 16, 2010, Dr. noted that the patient continued to have low back pain rated as 4/10 with discomfort with side-to-side movements, soreness and stiffness. She was happy with the surgical results which had helped her with lower extremity symptoms. She had more soreness from her incision sites. X-rays of the lumbar spine showed a fusion present at L5-S1, in good position and good alignment, with anterior and posterior hardware present. Dr. recommended starting the patient on an aggressive postoperative PT program for her lumbar spine and advised her to discontinue the use of a walker and increase her mobility.

On December 23, 2010, Dr. noted that postoperative PT therapy program was denied by her insurance carrier. She had intermittent low back pain. She experienced occasional right-sided numbness and tingling in her right lower extremity. X-rays of the lumbar spine showed a fusion at L5-S1 with anterior and posterior hardware, in good position and good alignment. Dr. opined that the patient needed postoperative PT to help strengthening her low back area. She was given informative handouts regarding PT to help increase mobility. Her medications were renewed.

On February 14, 2011, Dr. noted that the patient had participated in a postoperative PT program and had increased her mobility, with little relief. She had intermittent low back pain with occasional numbness and tingling down the right lower extremity. Dr. recommended additional PT to improve lumbar spine strengthening.

On April 14, 2011, Dr. noted that the patient had been participating in home PT and had increased mobility with some relief. She had low back pain with some discomfort with side-to-side movements, occasional soreness and stiffness. She had occasional pain that radiated down her right lower extremity. Examination of the lumbar spine showed tenderness in her mid to lower lumbar region with decreased ROM to extension. SLR elicited mid-back pain only. Diagnosis was status post anterior-posterior discectomy and fusion at L5-S1, spondylolisthesis, instability, neurogenic claudication and painful hardware. Dr. recommended additional PT in conjunction with her medication and recommended monitoring her progress.

From April 19, 2011, through May 13, 2011, the patient attended nine sessions of PT at South Texas Rehab consisting of therapeutic exercise, mobilization/manual therapy, body mechanics training, moist heat, cold pack, ultrasound, electrical stimulation, light therapy and postural education.

On May 31, 2011, the request for TENS supplies electrical stimulator was denied.

On July 7, 2011, Dr. noted that the patient was happy with the results of the surgery date to her low back. She continued to have persistent pain that radiated down her right lower extremity. Her pain level was 8/10. She had discomfort with side to side movements, soreness and stiffness. She had numbness and tingling present in her foot. Examination of the lumbar spine showed tenderness in her lower lumbar region over her pedicle screws, decrease in ROM with flexion and extension, positive SLR on the right eliciting back pain and leg pain, negative on the left. Her motor strength was weakened in to her right EHL, she had diminished sensation in her right S1 distribution. Her gait was slow. She was unable to do heel walk and toe walk due to pain in her right lower extremity. Dr. believed that the patient was experiencing some right S1 radiculitis or radiculopathy. Dr. recommended a lumbar ESI and conjugation with post injection PT and a CT myelogram of her lumbar spine to evaluate her nerve roots and evaluate the status of her fusion.

On August 15, 2011, lumbar CT myelogram showed: (1) Mild bilateral L5-S1 facet osteoarthritis due mostly to spurs from L5-S1 facets. (2) Surgical changes at L5-S1. There was partial bony bridging of the interbody fusion at L5-S1. There was no evidence of bony bridging of the posterolateral fusion at L4-L5 or L5-S1. (3) There was a small focus of nondependent intragenic air in the thecal sac at the L3-L4 level. (4) There was no evidence for hardware failure or loosening.

In October 2011, Dr. noted that the patient's left leg shooting had disappeared. She still had right-sided burning and numbness and some hip cramps. The right leg was a little better than it was prior to surgery, but not as good as she had hoped. Examination showed lumbar tenderness with well-healed incision, weakened right Achilles reflex when compared to the left. She had paresthesia along the right L5 distribution. Dr. reviewed a CT myelogram dated August 15, 2011. The radiologist had described partial bony bridging and this would suggest that the bone did not actually bridge from vertebra to vertebra; however, what one sees on the actual films was that there are some areas of bridging bone but the entire interbody fusion area had not completely bridged. In addition, there appeared to be almost complete bridging of the left posterior lateral fusion mass; however, on the right it was very incomplete. In addition, the radiologist commented on insufficient fusion at L4-L5; however, L4-L5 was an un-operated site. There should not be any fusion at L4-L5. Dr. assessed right-sided pseudarthrosis at L5-S1 and opined that the patient would probably need to bone graft the right posterior lateral fusion mass. He recommended a preoperative EMG to evaluate the neurologic status of the patient.

On December 15, 2011, M.D., performed a peer review and rendered the following opinions: If the current treatment plan was additional bone graft supplemented to the right posterior lateral fusion mass, this was a reasonable treatment for a failed fusion at that point. This was not addressed in the ODG. At that point, the medical record suggested that the patient was actually much worse off since the surgery than she was prior to the surgery with regard to both function and comfort. It was not clear whether or not the surgery was ever agreed as accepted treatment for the injury event at issue. Nonunion of an attempted spinal fusion was a known complication of attempted fusion. Whether or not treatment of a complication of an unapproved procedure was reasonable at that point was an administrative decision, not a medical point. With regard to the medical necessity of her current medications, the patient continued to require pain medication including narcotics and tramadol as well as a benzodiazepine sleeping pill on what appears to be a daily basis for a prolonged period of time. Her medications were likely necessary given her continued significant discomfort subsequent to her surgery a year ago. It was not unreasonable to suggest that she had dependency on these

medications and would require a supervised period of detoxification or weaning at some point in the future.

**2012:** On March 9, 2012, M.D., performed an EMG of the bilateral lower extremities. His interpretations were as follows: (1) There was neurophysiologic evidence of lumbosacral radiculopathy at L5 bilaterally status post lumbosacral spine surgery. (2) The denervation/reinnervation changes on needle EMG were chronic and moderate. (3) There was no neuropsychological evidence of peripheral neuropathy/myopathy. Dr. Chu opined that the patient might have a complex regional pain syndrome (CRPS) in the distal leg on the right.

On March 26, 2012, Dr. noted that the patient continued to have low back pain rated as 5/10 with constant pain in the back area, discomfort with side-to-side movement, soreness and stiffness. She had occasional lower extremity symptoms, right side greater than left. Examination of the lumbar spine showed tenderness on her mid to lower lumbar region with decreased ROM with flexion and extension, some paresthesias along right L5 distribution, weaker Achilles reflexes on the right when compared to the left and mild discomfort in her low back on heel-to-toe walk. Dr. reviewed the EMG findings and recommended proceeding with a bone graft to the right posterior lateral fusion mass at L5-S1. The patient was maintained on medications.

On April 11, 2012, Dr. reviewed the first denial letter regarding the recommended surgical plan. The physician review was performed by Dr., who stated that the last study was some five-six months ago. He went on to state simple x-rays and if need be, CT scan of the lumbar fusion mass at L5-S1 level should occur and be recent relative to the request for surgical intervention. He went on to state that no preoperative psychosocial screening had been performed recently. Dr. opined that the patient did not need to undergo a psychosocial screening. He recommended resubmitting request for the procedure and if denied again, withdrawing the request in proceeding with a CT scan to evaluate the bone mass at L5-S1 level.

On May 29, 2012, non-contrast lumbar CT scan showed: (1) Mild bony bridging at L4 posterior lateral fusion. No complete bony bridging across the right L5-S1 posterolateral fusion was confirmed. (2) There was mild partial bony bridging across the posterior aspect of the L5-S1 interbody graft. (3) The left L5 pedicle screw reached the superior endplate of L5 with mild partial extension into the left L4-L5 disc space. (4) There was no evidence of hardware loosening. (5) There was no significant canal or foraminal stenosis identified.

On June 28, 2012, Dr. reviewed the CT scan of the lumbar spine which showed incomplete bridging at L5-S1 on the right and mild bridging at L5-S1 on the left. Examination of the lumbar spine showed tenderness on the right side of her back, along well-healed surgical incision. The patient had diminished sensation along the right L5 distribution. Dr. opined that the psychosocial screen dated September 28, 2009, was normal. He recommended refilling the medications by changing her Lorcet to Lortab. He recommended revising the posterolateral fusion masses to get more complete healing posteriorly and obtaining flexion and extension views to check for any instability.

On July 23, 2012, Dr. noted that the patient continued to have low back pain rated as 4/10 with discomfort with side-to-side movements, soreness and stiffness. She had occasional lower extremity symptoms. Examination of the lumbar spine showed tenderness on the mid to lower lumbar region with decreased ROM with flexion and

extension, decreased along right L5 distribution. Dr. obtained x-rays of the lumbar spine in flexion and extension views which showed approximately 4 mm of translation between flexion and extension views. Diagnosis was pseudarthrosis at L5-S1 posteriorly with some instability noted. Dr. recommended proceeding with bone grafting to the right posterior lateral fusion mass at L5-S1 this helping to fuse up L5-S1 and preventing additional instability.

On August 10, 2012, x-rays of the lumbar spine showed fusion at L5-S1 with posterior hardware in place along with anterior screws at the level of the L5-S1 disc space. Alignment and disc spaces were normal and no fracture was seen. A slight scoliosis was present.

On December 17, 2012, Dr. noted that the request for surgery was denied. The patient continued to have low back pain rated as 5/10 with constant pain, discomfort with side-to-side movements, soreness and stiffness. She continued to experience a popping and clicking sensation in her low back area as well as occasional lower extremity symptoms. Examination of the lumbar spine showed tenderness upon palpation with decreased ROM with flexion and extension. The patient continued to experience diminished sensation along her right L5 distribution. Her lower extremities motor strength was mildly weaker on the right when compared to the left and her sensation was intact. Diagnosis was pseudarthrosis at L5-S1 posteriorly with some mild instability. Dr. recommended submitting a request for bone grafting to the right posterior lateral fusion mass at L5-S1. The patient's medications were renewed.

Per utilization review dated January 1, 2013, the request for one bone graft to right posterior lateral fusion mass at L5-S1, evaluate and explore of posterolateral fusion between December 17, 2012, through March 11, 2013, was denied with the following rationale: *"It does not appear that the patient meets the ODG criteria for fusion. As stated above, one of the indications for fusion surgery is spinal instability. The ODG states that spinal instability criteria include a lumbar inter-segmental movement of more than 4.5-mm. As stated in the July 23, 2012, progress report, the flexion/extension x-rays revealed only a 4-mm translation between the flexion and extension views. Based on these findings, the patient does not qualify for the requested spinal fusion. Therefore, the request for 1 bone graft to the right posterior lateral fusion mass at L5/S1 and evaluation and exploration of posterolateral fusion is recommended non-certified."*

Per reconsideration review dated January 25, 2013, the request for one bone graft to right posterior lateral fusion mass at L5-S1, evaluate and explore of posterolateral fusion between December 17, 2012, through March 11, 2013, was denied with the following rationale: *"It does not appear that the requested bone graft to the right posterior lateral fusion mass at L5/S1 and exploration is medically warranted. As stated before, the ODG clearly states that surgically induced spinal instability is an indication for fusion surgery and the requirements for spinal instability include lumbar inter-segmental movement of more than 4.5 mm. The patient's July 23, 2012, progress report indicates that the flexion/extension x-rays revealed only a 4-mm translation of the flexion and extension views. Based on these findings, the patient does not meet the ODG requirements for fusion surgery. As stated before, the provider did not submit any new information to support an alternative determination. Based on these findings, the request for 1 bone graft to the right posterior lateral fusion mass at L5/S1 and evaluate and explore of posterolateral fusion is recommended non-certified."*

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

The medical records support revision bone graft surgery given there has been a previous fusion surgery, persistent lumbar spine pain. Examination revealed decreased range of motion with flexion and extension, diminished sensation along the right L5 distribution and right lower extremity strength was decreased when compared to the left. CT scan demonstrated pseudoarthrosis and appropriate nonoperative care to date. Diagnosis was L5-S1 pseudoarthrosis. Official Disability Guidelines states, "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% 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." The claimant has neuro changes, persistent pain with a documented pseudoarthrosis. Based upon these findings, revision fusion surgery with bone grafting is appropriate and reasonable.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**