MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
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# Notice of Independent Review Decision

**DATE OF REVIEW:** **December 21, 2012**

**IRO CASE #:**

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

***360 L5-S1 fusion***

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

This case was reviewed by a board certified Orthopaedic Surgeon currently licensed and practicing in the State of Texas.

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

| Type of Document Received | Date(s) of Record |
|---|---|
| | |
| Physical therapy notes | 06/09/2011 to 06/27/2011 |
| H&P report by XXXX, MD | 06/16/2011 |
| EMG/NCS of upper and lower extremities | 08/16/2011 |
| H&P followup report by XXXX, MD | 02/06/2012 |
| MRI of the lumbar spine | 03/01/2012 |
| H&P followup report by XXXX, MD | 03/05/2012 |
| Office visit by XXXX, MD | 05/02/2012 |

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| Operative report (ESI) by XXXX MD | 05/31/2012 |
| Office visit by XXXX, MD | 06/07/2012 |
| H&P followup report by XXXX, MD | 08/20/2012 |
| CT Myelogram of the lumbar spine | 09/10/2012 |
| SOAP note by XXXX, MD | 09/12/2012 |
| Pre-surgical consultation and behavioral assessment report by XXXX, MA, LPC, LCDC | 10/09/2012 |
| A request for an IRO for the denied services of "360 L5-S1 fusion" | 12/04/2012 |

**EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This is a male who sustained work-related injury while he was working. He was involved in a motor vehicle accident while he was waiting at an intersection and another driver struck his vehicle from behind. As a result, he sustained injury to his neck and lower back. He was initially evaluated by Dr. XXXX and was treated with physical therapy. He was then seen by Dr. XXXX who recommended MRI of the lumbar spine, which was done on 03/01/2012 which showed disc protrusion at L5-S1 with impingement on right S1 nerve root. He then followed up with Dr. XXXX who recommended ESI which was done on 05/31/2012 without much relief. Subsequently, he again followed up with Dr. XXXX who recommended lumbar L5-S1 fusion

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

I reviewed the chart including the previous denials and the medical notes by Dr. XXXX. The ODG's described in the denial's were read and they make sense. But clinically Dr. XXXX states that "the extent of the decompression needed would create iatrogenic instability that would require fusion" and "the extent of disc desiccation and annular tearing, his low back pain would not respond to laminectomy alone…." I agree with these two statements. Based on my clinical experience, I have seen it numerous times where the bilateral laminectomy is done and the instability develops subsequently necessitating fusion. The ODG's do not discuss this particular case and therefore are not used in my determination to overturn the denial.

**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: (1) 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. (Andersson, 2000) (Luers, 2007)] (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 pre-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. (Andersson, 2000) (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% 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 ODG criteria. (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)
For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

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**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**

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☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

**X** **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

**X** **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)**