

MAXIMUS Federal Services, Inc.  
4000 IH 35 South, (8th Floor) 850Q  
Austin, TX 78704  
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

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**Notice of Independent Review Decision**

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** April 29, 2013

**IRO CASE #:**

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

Translateral lumbar interbody fusion with post spinal fusion at L3-L5 and spinal monitoring (22612, 22614 x 2, 22630, 22632, 22842, 22851 x 2, 20930, 20937, 95920, and 95926).

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

M.D., 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)

I have determined that the requested translateral lumbar interbody fusion with post spinal fusion at L3-L5 and spinal monitoring (22612, 22614 x 2, 22630, 22632, 22842, 22851 x 2, 20930, 20937, 95920, and 95926) is not medically necessary for the treatment of the patient's medical condition.

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

1. Request for a Review by an Independent Review Organization dated 4/08/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/08/13.
3. Notice of Assignment of Independent Review Organization dated 4/09/13.
4. Denial documentation.
5. Work Comp Pre-Auth Request Form dated 2/26/13 and 3/28/13.
6. Medical records from, MD dated 12/06/12, 1/15/13, and 3/07/13.
7. Medical records from DO dated 2/23/12 and 12/13/12.
8. Letter from Dr. PhD, LPC dated 3/27/13.
9. Pre-surgical Behavioral Health Evaluation dated 3/25/13.
10. Request for Preauthorization dated 3/11/13.
11. MRI of the lumbar spine dated 3/23/12 and 11/21/12.
12. Report of Medical Evaluation dated 11/08/12.
13. Functional Capacity Evaluation dated 11/29/12.

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

The patient is a male who reportedly was injured on xx/xx/xx. The patient underwent an electrodiagnostic study on 2/23/12 that revealed findings consistent with L5-S1 radiculopathy. On 11/21/12, an MRI of the lumbar spine revealed broad-based disc bulges at L2-S1 with mild bilateral foraminal stenosis, except for moderate stenosis at the L4-5 level. On 12/06/12, the patient reported back and leg pain. The patient had been previously treated with three epidural steroid injections, chiropractic care, work conditioning, and diagnostic studies. On examination, the patient had decreased lumbar spine range of motion, decreased left lower extremity motor strength, depressed Achilles reflexes, decreased sensation to bilateral lower extremities, and positive bilateral straight leg raise. The patient was recommended for laminectomy and interbody fusion at L3-4 and L4-5. The patient has requested coverage for translateral lumbar interbody fusion with post spinal fusion at L3-L5 and spinal monitoring (22612, 22614 x 2, 22630, 22632, 22842, 22851 x 2, 20930, 20937, 95920, and 95926).

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial indicated that the medical records do not support a two-level fusion to the lumbar spine. Per the URA, if the patient was a candidate for lumbar fusion, a psychological evaluation must be completed prior to surgical interventions. On appeal, the URA indicated that ODG criteria indicate that the requested services may be indicated if there are physical findings which correlate with the imaging studies, documentation of failure of conservative care, and all pain generators have been identified and

treated. Per the URA, it does not appear as if all pain generators have been identified and/or successfully treated prior to undergoing this surgical intervention.

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

The documentation submitted for review indicates that the patient has complaints of low back pain radiating to the bilateral lower extremities despite conservative care, including medications, therapy, and epidural steroid injections. The patient does have imaging, physical examination, and electrodiagnostic evidence consistent with lumbosacral radiculopathy. However, there is a lack of imaging evidence to support the necessity of a two-level lumbar fusion. Official Disability Guidelines recommend fusion when all pain generators are identified and treated, and when there are x-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography and MRI demonstrating disc pathology. Per the submitted records, there are no flexion and extension radiographs submitted for review demonstrating instability at the proposed surgical levels. Furthermore, the patient has electrodiagnostic evidence and MRI pathology at L5-S1 that has not been addressed. Thus, the requested services are not medically indicated for the treatment of this patient.

Therefore, I have determined the requested translateral lumbar interbody fusion with post spinal fusion at L3-L5 and spinal monitoring (22612, 22614 x 2, 22630, 22632, 22842, 22851 x 2, 20930, 20937, 95920, and 95926) is not medically necessary for treatment of the patient's medical condition.

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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**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGMENT, 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)**