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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** October 27, 2015

**IRO CASE #:**

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

Two to three day inpatient minimally invasive anterior instrumented fusion at L4-L5 for the lumbar spine.

**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 two to three day inpatient minimally invasive anterior instrumented fusion at L4-L5 for the lumbar spine is not medically necessary for the treatment of the patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who sustained a low back injury on XX/XX/XX. On xxx, lumbar spine magnetic resonance imaging (MRI) findings documented a broad-based disc bulge closely abutting the adjacent thecal sac. There was a fairly significant extension laterally into the L4 neural foramina on each side, with close abutment of the bilateral L5 nerve roots. On xxxx, lumbar spine x-ray findings documented an 8 mm anterior displacement of L4 with respect to L5 and 7 mm anterior displacement of L5 with respect to S1. These grade 1 spondylolistheses

remained stable with flexion and extension. On xxxx, the records noted low back pain radiating into the right buttocks/hip area down to the anterior thigh. When sedentary, his pain was rated grade 3-4/10. As soon as he began to walk or stand, pain increased to grade 7-8/10. The patient was a current smoker. Physical examination documented slightly antalgic gait, mild decrease in active range of motion, right-sided paraspinal muscle spasms, 5/5 lower extremity muscle strength, negative straight leg raise, and decreased sensation along the right L4/5 dermatomal distributions. The patient's diagnoses included lumbar spondylolisthesis, sciatica, lumbago, and lumbar disc displacement. The patient had not improved despite pharmacotherapy and lumbar epidural steroid injection. A request has been submitted for two to three day inpatient minimally invasive anterior instrumented fusion at L4-L5 for the lumbar spine.

The URA noted that the requested services are not medically necessary. The initial denial noted there is not a clearly defined objective radiculopathy or imaging evidence of segmental instability. On appeal, the URA noted there is no documentation of any lumbar spinal instability on flexion and extension x-rays as required by Official Disability Guidelines (ODG). Additionally, the URA noted, lumbar fusion is not supported for degenerative disc disease, disc herniation, or spinal stenosis without instability. Also, there is no documentation of a psychosocial screening with confounding issues addressed as required by ODG.

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

The Official Disability Guidelines (ODG) recommend lumbar spine fusion as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to pre-surgical clinical indications below: spondylolisthesis (isthmic or degenerative) with at least one of these: instability, and/or symptomatic radiculopathy, and/or symptomatic spinal stenosis; disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level; revision of pseudoarthrosis (single revision attempt); unstable fracture; dislocation; acute spinal cord injury (SCI) with post-traumatic instability; spinal infections with resultant instability; scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity; Scheuermann's kyphosis; or tumors. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or 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 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria include lumbar intersegmental translational movement of more than 4.5 mm. Preoperative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least six weeks prior to surgery and during the period of fusion healing. Relative to inpatient care, the ODG recommend median and best practice target length of stay for anterior lumbar fusion of three days.

The ODG criteria have not been fully met. This patient presents with persistent and function-limiting low back pain radiating into the right lower extremity to the anterior thigh. Clinical examination documented decreased L4-5 dermatomal sensation. There was imaging evidence of nerve root compromise at the L4-5 level. Evidence of reasonable and/or comprehensive nonoperative treatment protocol trial and failure has been submitted. There is radiographic evidence of grade 1 anterolisthesis at L4-5 and L5-S1. However, there is no evidence of instability on flexion and extension. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. This patient is a current smoker with no evidence of smoking cessation consistent with guidelines. There was no evidence of a psychosocial screen. Based on ODG, the requested services are not medically necessary for the treatment of this patient.

Therefore, I have determined the requested two to three day inpatient minimally invasive anterior instrumented fusion at L4-L5 for the lumbar spine is not medically necessary for treatment of the patient's medical condition.

**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)