

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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DATE OF REVIEW: **APRIL 24, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar fusion and LSO Brace

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

MD, 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Documents provided by including Health Direct correspondence dated 3/19/07; appeal dated 3/21/07; ODG-TWC Guidelines [Low Back – Lumbar & Thoracic (Acute & Chronic)]
- dated 12/1/06, 3/3/07
- 12/11/06, 12/27/06, 1/3/07, 1/11/07
- 1/5/07, 1/19/07, 2/5/07, 3/21/07
- PT Record; 1/2/07 – 2/16/07
- Radiology Report dated 3/1/07
- Operative Report dated 3/1/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant was seen by Dr. with complaints. He was a male with complaints of low back and radiating pain into his hips and legs bilaterally but more pain on his right leg. He had injured his back at work after a fall at which he broke several ribs and transverse processes of the lumbar spine. His history was reviewed and his pain symptoms were detailed. Social history was pertinent for the fact that he smoked a pack of cigarettes per day for 15 years. Pertinent findings on physical examination included the claimant was ambulating with an antalgic gait. He was noted to have mild weakness of the extensor hallucis longus on the right side. Diagnostic studies were reported including evidence on MRI of a herniated lumbar disk at L5-S1, which encroached on the neuroforamina bilaterally more on the right side with both L5 nerve root compression as well as some S1 compression and some extension into the lateral recess and into the extraforaminal area. The impression was herniated lumbar disk with back and extreme pain. Physical therapy was recommended and possible epidural steroid injections.

The patient was treated in physical therapy beginning on 12/11/06 with complaints of back and right lower extremity pain. He attended several sessions of physical therapy until 1/4/07. He was noted during these visits to have continued complaints of pain.

On 1/5/07, the claimant saw a nurse practitioner with complaints of lower back pain with notations that physical therapy had made it worse. The examination showed, on this occasion, mild weakness of the tibialis anterior and extensor hallucis longus on the right as well as an antalgic gait. The impression was lumbar back pain with radiculopathy secondary to herniated L5-S1 disk. The patient was referred for consideration of epidural steroid injections.

On 1/19/07, the records indicate that the claimant had an L5-S1 epidural steroid injection by Dr.. On 2/5/07, he was seen again by the nurse practitioner with notations that the epidural steroid injection had only helped him minimally. He had not been able to return to work light duty and had persistent pain in his back and right leg. Examination showed symmetrical reflexes and a notation that there were no clear-cut weaknesses of the lower extremities. A myelogram CT scan was scheduled for the patient.

On 3/1/07, he had a lumbar myelogram showing normal spinal alignment with multilevel degenerative disk changes, osteophyte formation with facet degenerative changes. He had small extradural defects at all levels of the lumbar spine but most prominent at L5-S1. There appeared to be some retrolisthesis of L2 on L3 on flexion extension views. There was some mild truncation of the left and right L5 nerve roots sleeves. Post myelogram CT scan demonstrated mild disk bulge at L2-3, broad based disk bulge at L3-4 with bilateral foraminal stenosis, disk bulge with foraminal stenosis at L4-5 and a prominent broad based disk bulge without discrete focal disk protrusion. There

was mild narrowing of the central canal and severe bilateral neuroforaminal stenosis.

On 3/21/07, the claimant again saw the nurse practitioner with persistent complaints of back and leg pain. He had not been able to return to work and noted that he was experiencing excruciating pain if he was up more than two hours. Bone density test was requested and the patient was continued on pain medications.

On 3/19/07, there is a recommendation for non-authorization of the surgical 360-degree fusion by Dr. It was noted that in absence of peer discussion that he could not recommend surgical treatment. It was noted that his imaging studies and clinical complaints appear to be somewhat inconsistent.

On 3/21/07, performed another review. Non-certification was recommended based on multilevel degenerative disk disease and bilateral foraminal stenosis without evidence of loss expected disk height, instability or listhesis. He also quoted *The Official Disability Guideline* indicating that lumbar fusion was not recommended for Workers' Compensation patients in absence of spinal fracture dislocation or spondylolisthesis. He also noted that the ODC-TWCC re-operative surgical guidelines indicated that all pain generators must have been identified and treated, all physical medicine and manual therapy interventions had been completed, and X-rays, MRI or CT demonstrated disk pathology and spinal instability and spine pathology was limited to two levels and that psychosocial screening showed no confounding issues.

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

THE ODG-TWCC GUIDELINES INDICATE THAT SPINAL FUSION IS NOT RECOMMENDED FOR PATIENTS UNLESS THERE IS EVIDENCE OF SEVERE STRUCTURAL INSTABILITY AND/OR ACUTE OR PROGRESSIVE NEUROLOGICAL DYSFUNCTION. IN THE ABSENCE OF SPINAL FRACTURE, DISLOCATION, SPINAL LISTHESIS OR FRANK SEVERE NEUROGENIC COMPROMISE, FUSION WOULD NOT BE INDICATED. PER THE OCCUPATIONAL PRACTICE GUIDELINES THERE IS NO SCIENTIFIC EVIDENCE REGARDING THE LONG TERM EFFECT OF ANY KIND OF SURGICAL DECOMPRESSION OR FUSION FOR DEGENERATIVE LUMBAR SPONDYLOSIS COMPARED WITH A NATURAL HISTORY OF THE DISEASE.

FURTHERMORE, THE *WASHINGTON STATE DEPARTMENT OF LABOR AND INDUSTRIES GUIDELINES* REGARDING LUMBAR FUSION NOTES THAT ABSOLUTE CONTRAINDICATIONS TO LUMBAR FUSION INCLUDE LUMBAR FUSION ASSOCIATED WITH AN INITIAL LAMINECTOMY, DISKECTOMY AND UNILATERAL COMPRESSION OF THE NERVE ROOT. RELATIVE CONTRAINDICATIONS INCLUDE CURRENT SMOKING AND MULTIPLE

LEVEL DEGENERATIVE DISK DISEASE BOTH OF WHICH THIS PATIENT DEMONSTRATES.

HE DOES HAVE SOME EVIDENCE ON CLINICAL EXAM AND IMAGING OF COMPRESSION AND DYSFUNCTION OF THE RIGHT L5 NERVE ROOT. IF EMG NERVE CONDUCTION STUDIES CONFIRM THE RIGHT L5 RADICULOPATHY, THEN CONSIDERATION FOR DECOMPRESSION OF THE RIGHT L5 NERVE ROOT WOULD BE AN APPROPRIATE PROCEDURE. HE HAS FAILED CONSERVATIVE CARE AND IF ELECTROPHYSIOLOGICAL STUDIES DEMONSTRATE DEFINITE NERVE ROOT DYSFUNCTION THEN DECOMPRESSION OF THE NERVE ROOT WOULD MOST LIKELY RESULT IN SOME DECREASE IN HIS LEG SYMPTOMS. IT IS UNLIKELY THAT HIS ACTUAL BACK PAIN WOULD BE AFFECTED BY SURGICAL INTERVENTION AND ESPECIALLY IN VIEW OF HIS MULTILEVEL DEGENERATIVE DISK DISEASE, A SINGLE LEVEL FUSION OR DISK REPLACEMENT AT L5-S1 WOULD NOT BE EXPECTED TO SIGNIFICANTLY IMPROVE HIS OUTCOME ON A LONG TERM BASIS. ADDITIONALLY, PSYCHOSOCIAL ASSESSMENT SHOULD BE UNDERTAKEN PRIOR TO CONSIDERING ANY TYPE OF SURGICAL INTERVENTION TO IDENTIFY ANY CONFOUNDING FACTORS, WHICH MIGHT INTERFERE WITH THE CLAIMANTS RECOVERY. FURTHER EVIDENCE REGARDING THE INADVISABILITY OF SPINAL FUSION IS FOUND IN *FTZLER ET AL'S* VOLVO AWARD WINNING STUDY OF 2001, IN WHICH A VERY SMALL IMPROVEMENT IN PATIENTS RECEIVING LUMBAR FUSION WAS NOTED COMPARED TO CONTROL PATIENTS WHO HAD NO FUSION. THERE WAS ALSO NOTED TO BE A SIGNIFICANT SURGICAL COMPLICATION RATE OF 17% FROM FUSION SURGERY THEREBY BRINGING INTO QUESTION THE VIABILITY OF LUMBAR FUSION.

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 FTZLER ET AL'S**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**