

Clear Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

AUGUST 28, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior/posterior lumbar fusion at L4-5 with iliac crest bone graft with a two-day inpatient length of stay

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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Lumbar spine MRI, 06/29/04

Office note, Dr., 07/09/04, 07/19/04, 10/08/04, 11/01/04, 05/26/05, 06/13/05, 08/17/05, 02/08/07, 06/15/07

Office note PA for Dr., 02/18/05

Operative report, 05/1/105

Discogram interpretation

Lumbar discography, 05/11/05

Post discography CT lumbar spine, 05/11/05

Phone call to claimant, 09/09/05

Note, 10/26/054

Operative report, Dr., 12/28/05

Medtronic form, 12/29/05

Disability evaluation, 11/03/06

Note form disability valuation, 11/03/06

Office note, FNP, 02/09/07

Letter of appeal, Dr., 04/15/07

Note from Practice Manager, 06/21/07
Review, Dr., 06/28/07
Note from Dr., 06/28/07
Review, Dr., 07/06/07
Note, 08/09/07
Patient ledger noted

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who felt a snapping sensation in his low back while moving a storage tank at work. Ultimately on 12/28/05 the claimant underwent an L5-S1 anterior discectomy and fusion with anterior cages with bone morphogenic protein and anterior plate and screws by Dr. Dr. indicated that while the preoperative history and physical indicated that the claimant had surgery to both L4-5 and L5-S1, that based on an intra-operative review of the MRI and prior to the surgical procedure, he elected not to do L4-5 as he felt that L5-S1 was primarily the pain generator and was much less degenerative than thought. The claimant's leg pain improved with surgery, but he had continued low back pain. On 11/03/06 the claimant was determined to be at Maximum Medical Improvement and was assigned a 10 percent whole person impairment.

The claimant presented to Dr. on 02/08/07 reporting decreased leg pain and worsened back pain. There was tenderness over the lumbosacral region on the right, abnormal rhythm reversal and bilateral low back pain with bilateral supine straight leg raise. X-rays of the lumbar spine showed anterior fusion hardware at L5-S1 without loosening or shifting. Dr. was suspicious that L4-5 was still contributing to the claimant's pain. Repeat Discogram was recommended and was denied.

FNP with pain associates, evaluated the claimant on 02/09/07 noting increased pain with weather changes, physical activities, standing, sneezing/coughing and physical therapy. He was working full time without restrictions and had the second facet intra-articular blocks at L2-3 and L3-4. Continued pain on lumbar flexion and extension, tenderness from L3-L5 at midline and over the right lumbar facet area were noted on examination. Strength was 5/5 on the left foot and 2/5 on dorsiflexion and 4/5 on plantar flexion of the right foot. Post-laminectomy syndrome and lumbar/thoracic radiculitis were diagnosed. Increasing Hydrocodone, discontinuation of Methadone, continuation of Soma and Lidoderm patches and a discogram were prescribed. Apparently the discogram was denied and later appealed.

Dr. re-evaluated the claimant on 06/15/07 noting the claimant's complaints of continued predominant low back pain radiating to both buttocks, typically greater on the left and locking sensations in the low back with standing longer than 5 minutes at a time. Dr. stated that the 05/05 discogram was positive at L4-5 and that authorization was given for fusion of both L4-5 and L5-S1, but the surgeon only addressed L5-S1. He stated that the L4-5 level needed addressed and therefore recommended an anterior posterior fusion of L4-5. The request was denied on two reviews; 06/28/07 and 07/06/07 each following physician discussion.

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

The Reviewer has been asked to address the need for an anterior posterior fusion at L4-5 with a two day length of stay. The claimant is 20 months post an L5-S1 lumbar fusion. He is noted to have persistent and worsening low back pain and decreased leg pain

despite various medications, and two facet blocks at L2-3 and L3-4. While the claimant's recent complete physical examination notes diminished strength on the right foot, this examination is six months old. The only postoperative diagnostic study provided is lumbar spine x-rays which reportedly show an anterior fusion of L5-S1 and no shifting or loosening. There are no current postoperative diagnostic studies or physical examination to document that the claimant has conclusive pathology at L4-5 or to indicate that there is instability. The examination findings that are provided are not clearly consistent with the L4-5 level. The claimant apparently was approved for fusion at both the L4-5 and L5-S1 levels, but the surgeon decided to only address the L5-S1 level. No special studies have recently been carried out and on the MRI the L4-5 level was generally unremarkable. Given all of this the proposed lumbar fusion at L4-5 with a two day length of stay cannot be recommended as being medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Fusion)

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 - Spondylytic spondylolisthesis, congenital unilateral neural arch hypoplasia. (2) Segmental Instability - 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. (3) Primary Mechanical Back Pain/Functional Spinal Unit Failure, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability, with and without neurogenic compromise. 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. (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.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography demonstrating disc pathology; & (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](#))

Milliman Care Guidelines, 11th Edition, Inpatient and Surgical Care

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 (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)