

Notice of Independent Review Decision

DATE OF REVIEW:

12/27/2007

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Transforaminal Lumbar Interbody fusion at L4-L5 and L5-S1.

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

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.

Transforaminal Lumbar Interbody fusion at L4-L5 and L5-S1 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Case Report dated 12/17/07
- Referral dated 12/17/07
- Case Report dated 12/03/07 from, MD with attached concurrence signed by, MD
- DWC: Notice To LLC Of Case Assignment dated 12/17/07
- DWC: Notice To Utilization Review Agent of Assignment dated 12/17/07
- DWC: Confirmation Of Receipt Of A Request For A Review dated 12/14/07
- LHL009: Request For A Review By An Independent Review Organization dated 12/13/07
- Request for Reconsideration of Adverse Determination dated 12/04/07
- Letter dated 11/21/07
- DWC: Report of Medical Evaluation signed 11/20/07
- Evaluation Centers: Required Medical Evaluation dated 11/20/07 from, MD
- DNI: Pre-Authorization Facsimile Transmittal dated 11/20/07
- DNI: Pre-Auth Request For A Lumbar Discogram (Reconsideration) from dated 11/15/07
- Letter dated 11/15/07 (first page only)
- Chronic Pain Evaluation dated 10/02/07
- Prescription note dated 09/29/07
- MD: Designated Doctor Report dated 07/10/07
- Radiology Associates: Chest x-rays dated 05/16/07
- Texas Inpatient Authorization Recommendations dated 02/22/07, 06/12/07



- M.D.: Office notes dated 01/08/07 through 10/29/07
- Diagnostic Imaging Center: Lumbar myelogram dated 11/22/06
- Surgery Center: Operative Report dated 11/07/06 from, M.D.
- MRI spine dated 10/05/06
- Patient Summary (handwritten) dated 10/11/06
- MD: Report dated 09/26/06
- NOTE: Carrier did not supply ODG guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a xx-year-old male who was reported to have sustained a work-related injury on xx/xx/xx. The mechanism of injury was when he twisted hard to the left he experienced back pain. Initial treatment details are not available regarding conservative treatment (NSAIDs, activity modification, active physical therapy, etc.). He eventually came under the care of M.D. an orthopedic spine surgeon. Electromyogram/Nerve conduction Velocity (EMG/NCV) studies were performed on 09/26/2006 by Dr. and interpreted as consistent with an acute right L5 radiculopathy. The MRI on 10/05/2006 was consistent with degenerative disc disease at L4-L5 and L5-S1. Lumbar myelogram with CT scan revealed degenerative disc disease at L5-S1 without either compression of the thecal sac or the S1 nerve roots. Dr. performed a lumbar epidural steroid injection on 11/07/2006 with only short-term improvement. He subsequently recommended surgery. His initial approach recommended was and anterior interbody fusion. The injured individual was to be scheduled for surgery in 04/2007, but laboratory testing was markedly abnormal and the surgery was placed on hold. This included a markedly elevated white count and elevated platelet count. The injured individual was then referred to other physicians to attempt to find out the etiology. He continued to follow with Dr. in the interim. Treatment at this point was mostly with medications. The injured individual was then found to have osteoporosis when bone densitometry was performed. M.D. performed a Designated Doctor Evaluation on 07/10/2007 and opined that the injured individual was not at maximum medical improvement (MMI). Psychologist completed a chronic pain evaluation on 10/02/2007. He felt that further psychological testing was indicated prior to any surgical procedure. A Required Medical Evaluation was done by M.D. on 11/20/2007. He indicated that the injured individual was not at MMI. Dr. then changed the requested procedure to a transforaminal two level fusion.

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

The injured individual is a xx-year-old male who was reported to have sustained a work-related injury on xx/xx/xx. The diagnosis most consistent with the reported mechanism of injury is an acute lumbar strain. He has had a protracted course without any improvement in his symptoms. There is a lack of documentation regarding initial treatment and response to conservative treatment. The Medical Disability Advisor’s length of disability for an injury of this magnitude:

Supportive treatment, lumbar or lumbosacral spine sprain or strain.

DURATION IN DAYS

Job	Minimum	Optimum	Maximum
Classification			

Sedentary	1	3	7
Light	1	7	14
Medium	3	14	28
Heavy	7	21	42
Very Heavy	7	28	56

The injured individual has far exceeded these parameters and not returned to work. Psychologist has recommended further psychological testing prior to any surgical procedure because of his concern about surgical outcome. Dr. has reported physical findings on 07/16/2007, which was not anatomical or dermatomal in nature. The injured individual has evidence of degenerative disc disease, which is pre-existing and a “disease of life”. Confounding factors include laboratory testing abnormalities of which the etiology has not been determined. The injured individual has significant osteoporosis, which is unusual for a xx-year-old and may impact the outcome of any surgical procedure. The source of his osteoporosis is ill-defined. The pain generator(s) have not clearly been defined in the medical record. There is no evidence of significant neural impingement demonstrated on any of the imaging studies. There is no evidence of instability.

The Official Disability Guidelines:

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. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (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. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (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; & (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](#))

The injured individual has not met the surgical indications as outlined above.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**