

I-Decisions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

(207) 338-1141 (phone)

(866) 676-7547 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 07/28/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar fusion L4/L5 plus 3 overnight inpatient stay (63047, 22612, 22630, 22842, 20936, 27299, 22851, 20938, 77002)

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

M.D., Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

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)

Upon independent review the reviewer finds that the requested lumbar fusion L4/L5 plus 3 overnight inpatient stay (63047, 22612, 22630, 22842, 20936, 27299, 22851, 20938, 77002) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 6/24/08, 7/2/08

ODG Guidelines and Treatment Guidelines

, MD 6/30/08, 6/18/08, 6/9/08, 6/24/08, 5/5/08, 4/21/08

Lumbar Spine X-Rays 3 Views 6/9/08

CT Lumbosacral Spine 4/21/08

Patient Selection Criteria 6/18/08

Pre-Authorization Request Sheets
Chronic Pain Evaluation 5/30/08
MRI Lumbar Spine 3/9/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year-old male with a date of injury xx/xx/xx. He is status post left L4-L5 microdiscectomy 02/29/2008. He did well initially but then began to develop back and left leg pain in April of 2008. His back pain is equal to his leg pain. An MRI March of 2008 showed at L4-L5 surgical changes of an L4 laminotomy and left sided discectomy with the remaining half of a broad-based bulge with minimal focal central protrusion and facet joint degenerative joint disease causing no significant stenosis or neuroforaminal narrowing. A CT of the lumbar spine 04/21/2008 with and without contrast showed postoperative changes and a vacuum phenomenon in the disc. This study is also suggestive of a recurrent disc at this level. Flexion and extension films of the lumbar spine 06/09/2008 showed no abnormal motion. He underwent a chronic pain evaluation 5/30/2008. No contraindications to spinal surgery were found. However, he did have some concerning results on some of his testing, such as a high pain score, indicating that "the mildest pain is seen as intolerable and disabling". Neurological examination reveals a 4+/5 left EHL weakness. The provider is recommending a lumbar fusion at L4-L5 with a three day length of stay.

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

The proposed lumbar fusion L4/L5 plus 3 overnight inpatient stay (63047, 22612, 22630, 22842, 20936, 27299, 22851, 20938, 77002) is not medically necessary. Although the patient has had greater than 6 months of conservative therapy since his date of injury, he has not had adequate conservative therapy since his surgery of 02/29/2008. Although not stated expressly by ODG, the fact that a surgery occurred and there was improvement from this surgery initially, should "set the clock back", so that a reasonable course of conservative therapy be undertaken before proceeding with another, larger procedure (except for extenuating circumstances). In this case, in particular, the patient has concerning issues raised on psychological evaluation, making the success of such a surgery less than ideal. For this patient, Treatment Guidelines recommend exhausting all conservative measures, and treating his radiculopathy, prior to undertaking a lumbar fusion.

References/Guidelines

ODG "Low Back"

2008 *Official Disability Guidelines*, 13th edition
"Low Back" chapter

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 disectomy. [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](#))

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 KNOWLEDGBASE
- 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)**