

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW: March 3, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-5, L5-S1 decompression, posterior lumbar interbody fusion with cages and posterior lumbar fusion with plate and screw fixation; three days 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

OD Guidelines

MRI lumbar, 12/14/06, 02/15/07

Office notes, Dr. 12/28/06, 02/15/07, 03/15/07, 04/05/07, 04/17/07, 04/23/07, 05/24/07, 06/21/07, 11/27/07

Office notes, Dr. 1/5/07, 02/01/07

Office note, Dr. 2/26/07

EMG/NCS, 3/8/07

DDE, Dr. 04/02/07

CT myelogram lumbar, 04/17/07

Lt L5 transforaminal NRB, 5/9/07

Lt L4 transforaminal NRB, 6/6/07

Letter, Dr. 7/3/07, 01/22/08

IME, Dr. 8/5/07

HEALTH AND WC NETWORK CERTIFICATION & QA 3/12/2008
IRO Decision/Report Template- WC

CT discogram lumbar, 11/19/07
Office notes, Dr. 11/26/07, 12/18/07
Review, Dr. 01/02/08
Review, Dr. 01/30/08
Medication list: No Date

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who sustained a low back injury while lifting a bag of coins. MRI evaluation performed on 12/14/06 noted disc desiccation at L3-4, L4-5 and L5-S1 with a mild L4-5 disc protrusion into the left foramen with possible left L4 nerve root impingement and L5-S1 bilateral facet arthropathy. She suffered an exacerbating event while exiting the MRI scanner that involved a pop in her low back and subsequent increased back and bilateral lower extremity pain. Physical examination on 12/28/07 demonstrated marked spasm and tenderness; markedly impaired left straight leg raise with a positive ankle dorsiflexor and bowstring sign; slight left extensor hallucis longus weakness; and decreased sensation in the left L5 dermatome. She treated conservatively with medications, epidural steroid injections times three and activity modification. Repeat MRI evaluation completed on 02/15/07 noted mild discogenic and spondylotic changes without significant spinal or foraminal narrowing at L4-5 and L5-S1; no focal disc herniations; mild congenital canal narrowing; and bilateral facet arthropathy at L3-4, L4-5 and L5-S1. On 02/26/07, Dr. indicated the claimant was not a surgical candidate at that time. Electrodiagnostic studies conducted on 03/08/07 were normal. A designated doctor evaluation by Dr. on 04/02/07 indicated the claimant was unable to sit; difficulty with activities of daily living; an antalgic gait; hyperactive bilateral lower extremity reflexes; bilateral lower extremity weakness, left greater than right; hypoesthesia along the left lateral foot consistent with the L5-S1 dermatome and in the right foot consistent with the L4-5 dermatome. She continued to treat with medications. CT/ Myelogram evaluation from 04/17/07 noted L3-4, L4-5 and L5-S1 diffuse bulging with mild retrolisthesis at L3-4 and facet hypertrophy. Dr. felt the CT demonstrated some foraminal narrowing at L4-5 and L5-S1 without a specific nerve root lesion. On 04/23/07 she treated with a Medrol dose pack for increased pain and headache that was felt to be related to the myelogram. She underwent left transforaminal nerve root block on 05/09/07 and a left L4-5 transforaminal nerve root block on 06/06/07; both provided some relief. Surgical decompression was recommended and denied. An independent medical examination completed on 08/05/07 by Dr. indicated the claimant had been over treated and simply required a conditioning program. The claimant was noted to require large amounts of narcotic analgesia. CT/ discogram evaluation from 11/19/07 noted a negative L2-3 level with positive L3-4, L4-5 and L5-S1. She again reported a flare of symptomatology after the study. She treated with pain management with reference to attending physical therapy on unknown dates. Surgical intervention to include decompression and fusion has been recommended by both Dr. and Dr.

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

The Reviewer does not see the medical indication for the requested L4 through S1 decompression, fusion, or three day length of stay. This medical record documents MRI studies with mild degenerative changes and a normal EMG. There is a 04/17/07 CT

myelogram documenting some degenerative changes but no clear evidence of a disc herniation or significant spinal stenosis and the medical records document ongoing subjective complaints without clear evidence of an anatomic reason for her complaints. While Dr. in a 07/03/07 letter documents a diminished straight leg raise and weakness of the foot, it is not clear as to exactly what is anatomically causing her problems. There are then further studies to include an 11/19/07 CT discogram documenting pain at multiple levels as well as ongoing medical records documenting her pain complaints without clear evidence of a true neurologic deficit or anatomic reason for her complaints.

Therefore, after a careful review of all medical records, the Reviewer's medical assessment is that this multilevel decompression and fusion with three day length of stay is not medically necessary due to the fact that this medical record does not clearly anatomically document a specific reason for her complaints or findings.

Milliman Care Guidelines, Twelfth Edition- Lumbar Fusion

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back-Fusion

-Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise

-After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended [conservative therapy](#). [For spinal instability criteria, see AMA Guides ([Andersson, 2000](#))] For complete references, see separate document with all studies focusing on [Fusion \(spinal\)](#). There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

-According to the recently released AANS/NASS Guidelines, lumbar fusion is recommended as a treatment for carefully selected patients with disabling low back pain due to one- or two-level degenerative disc disease after failure of an appropriate period of conservative care. This recommendation was based on one study that contained numerous flaws, including a lack of standardization of conservative care in the control group.

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 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](#))

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)**