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Notice of Independent Review Decision

DATE OF REVIEW: 05.23.2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 level L-Lami/disc, decomp fusion and instrumt

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
2 level L-Lami/disc, decomp fusion and instrumt	63047, 63048, 22612, 22614, 20902	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Utilization Review		1	04.30.08	04.30.08
2	Office Visit		2	04.17.08	04.17.08
3	Diagnostic		2	02.07.08	02.07.08
4	Utilization Review		6	04.21.08	04.21.08
5	Utilization Review		4	05.02.08	05.02.08

PATIENT CLINICAL HISTORY [SUMMARY]:

The request is for an IRO regarding L4 to S1 laminectomy/discectomy, fusion with internal fixation with a length of stay of 2-3 days. The requesting physician is Dr. .

Brief history:

The patient is a xx year old male who fell on xx/xx/xx when he slipped at work, landing on his left iliac crest. The shoulder problem resolved, but he continues with chronic low back pain and bilateral leg, right greater than left. He ahs failed reportedly, P.T. and medication. On 04/17/08, findings were normal tandem walking and heel and

toe walking without any problem. Reflexes were normal, tone and strength was normal. There was decreased sensation on the left L5S1 dermatome. The patient was stated to want surgery and the last sentence on the exam paragraph stated that neurologically, he had decreased strength on the right leg. MRI revealed an L5S1 grade I spondylolisthesis with circumferential bulging and facet hypertrophy causing severe bilateral foraminal stenosis impacting the exiting L5 nerve root, right greater than left. There was a disc/osteophyte complex. L4-5 had a central focal disc extrusion with annular tear and moderate circumferential bulging with severe facet hypertrophy causing moderate foraminal narrowing with minimal nerve root compromise right greater than left. Reportedly, an exam done on 04/02/08 denoted all four extremities having normal strength.

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

The patient is a xx year old male with a 4 month history of LBP and bilateral leg pain. Reportedly, he has failed conservative care but this is not described (medical records only stated he had failed P.T.). It does not state whether cognitive behavioral treatment with an aggressive rehab protocol was used because this has been found to be as effective as lumbar fusion (Fairbanks-BMJ, 2005) (Brox, 2006) without the potentially high complication rate and the morbidity associated with post-op pain and the stiffness and loss of lumbar ROM associated with the inevitable spine fibrosis and deconditioning. Also, there are no flexion/extension films to evaluate for instability which is one of the important criteria for a lumbar fusion nor is there documentation of a true radiculopathy (loss of reflexes or 2cm atrophy of one of the lower extremities).

There are inconsistencies in the documentation of right leg weakness. 04/02/08 exam documented normal; strength. The treating surgeon documented conflicting findings of right leg strength within the same paragraph on 04/17/08. Also, pre-surgical psychological testing to include psychometric testing as recommended (ODG and ACOEM) has not been done. There are also inconsistencies in the recommended levels to be fused. The clinical notes by the treating surgeon recommend surgery at the L5S1 level. He does not mention the L4-5 level. Yet, when he requests certification for surgery, he includes the L4-5 level as well for decompression, fusion and instrumentation. Therefore, based upon the above rationale, and peer- reviewed criteria, the L4-5 and L5S1 surgical procedure along with an LOS of 2-3 days is not certified.

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.

([Andersson, 2000](#)) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

([EMGs](#) are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1) B.

Lateral disc rupture

C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. [MR](#) imaging
2. [CT](#) scanning
3. [Myelography](#)
4. [CT myelography](#) & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. [Activity modification](#) (not bed rest) after [patient education](#) (>= 2 months) B.

Drug therapy, requiring at least ONE of the following:

1. [NSAID](#) drug therapy

2. Other analgesic therapy
 3. [Muscle relaxants](#)
 4. [Epidural Steroid Injection](#) (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
1. [Physical therapy](#) (teach home exercise/stretching)
 2. [Manual therapy](#) (massage therapist or chiropractor)
 3. [Psychological screening](#) that could affect surgical outcome
4. [Back school](#) ([Fisher, 2004](#))

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 - 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:

ODG:

ODG on-line, Treatment, Low back, fusion and discectomy/laminectomy criteria