

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 05/03/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy with fusion, 1 day length of stay

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 inpatient lumbar laminectomy with fusion, one day length of stay is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 3/20/08, 4/3/08

ODG Guidelines and Treatment Guidelines

MD Letter DC 3/27/08, 3/13/08, 6/1/06

Patient History

MD Notes 3/3/08

Previous IRO Decision 7/17/07

MD Follow-Up Office Visit 7/3/07, 4/10/07

Referral 7/3/07, 4/10/07

Office Visit Dr. 6/1/07
Report of Medical Evaluation 12/21/06
Review of Medical History and Physical Exam 12/21/06
Impairment Rating Report 12/21/06
Operative Report of Discogram 11/30/06
CT of Lumbar Spine Post Discogram 11/30/06
ODG Guidelines Fusion (spinal)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male has a date of injury xx/xx/xxxx. The patient has mechanical back pain as well as radiating hip and leg pain, left greater than right. The back pain is as severe as his leg pain. The patient has had epidural steroid injections and done home exercises as well as pain management. He is incapacitated by his pain. Neurological examination reveals decreased sensation in the left L5 dermatome with weakness of plantar flexion and dorsiflexion on the left. He has an absent left ankle reflex. An MRI of the lumbar spine 02/28/2008 reveals a left paracentral disc protrusion at L4-L5, deforming the thecal sac and displacing the neural elements. There is disc desiccation at this level as well. The discogram showed concordant pain at L4-L5 with a negative control. The patient is a long-time smoker (presently, he smokes 3 cigarettes a day). The provider is recommending an L4-L5 posterior decompression and fusion.

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

Upon reviewing the medical records the reviewer finds that an inpatient lumbar laminectomy with fusion, one day length of stay is medically necessary. The patient has had a long course of conservative therapy and still is having mechanical back and leg pain. His imaging studies reveal abnormalities at L4-L5 and his discogram was positive at this level as well. He also has radicular findings referable to this level. Although he is a smoker, he has cut down on his smoking, and should not be denied this procedure for this reason. He does meet the ODG criteria for lumbar fusion, as listed below. It is very likely that his pain generator is from the L4-L5 level.

References/Guidelines

ODG "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 - 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 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 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)**