

## **I-Resolutions Inc.**

*An Independent Review Organization*

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### **Notice of Independent Review Decision**

**DATE OF REVIEW: MAY 16, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Decompression and Fusion @L4-S1 with bone graft and instrumentation

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

MD, 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)

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.

The reviewer finds that medical necessity exists for Decompression and Fusion @L4-S1 with bone graft and instrumentation.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Letters, SRS, 03/05/08, 03/13/08

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

Office notes, Dr. 6/15/06, 9/7/06, 9/25/06, 12/4/06, 2/8/07, 3/8/07, 05/10/07, 06/28/07, 08/21/07, 09/24/07, 10/22/07, 11/05/07, 11/19/07, 12/17/07, 02/28/08, 03/06/08, 03/31/08

ESI, 09/18/06

Note, Dr. , 01/23/07, 01/22/08

Computerized ROM and Muscle Testing, 03/08/07, 05/10/07, 06/28/07, 08/21/07, 10/22/07, 11/19/07, 12/17/07, 03/31/08

Therapy notes, 05/09/07, 06/18/07

FCE, 08/06/07

MRI lumbar, 10/12/07

EMG/NCS, 11/08/07

Request for authorization 03/03/08 3-3-08

Psych Evaluation, 03/11/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a XX year-old male who sustained a low back injury on XX/XX/XX while lifting an eighty pound propane cylinder. He then reported right lower extremity pain with foot numbness that resulted in a slap gait. Physical examination demonstrated true nerve root tension signs with a positive right straight leg raise; weakness of the right tibialis anterior and extensor hallucis longus; and decreased sensation in the right L5 dermatome. MRI evaluation performed on 05/19/06 noted a large right disc herniation at L4-5 that caused both thecal sac and nerve root compression. The claimant treated with a Medrol dose pack and Gabapentin with minimal improvement. He underwent epidural steroid injection on 09/18/06 with some initial improvement and persistent severe right leg pain. A decompressive laminectomy at the right L4 and L5 was conducted on 01/23/07 with improvement of his right lower extremity symptoms postoperatively. He attended postoperative physical therapy in May of 2007. Therapy notes indicated improvement in right lower extremity strength. On 06/28/07 the claimant reported his pain was tolerable and he was able to function. A functional capacity evaluation completed on 08/06/07 noted the claimant did not meet the physical demands of his job and was only able to function in the sedentary to light category. He attended a work conditioning program that increased his pain and he developed a new onset of left lower extremity symptomatology with numbness to the great toe. Repeat MRI evaluation on 10/12/07 noted L4-5 right disc protrusion that narrowed the right lateral recess and contacted the L5 nerve root with moderate left foraminal stenosis and minimal fibrosis; as well as L5-S1 grade I spondylolisthesis with severe left and moderate right foraminal stenosis and compression of the left L5 nerve root. Physical examination demonstrated weakness of the left tibialis anterior. Electrodiagnostic studies conducted on 11/08/07 noted the claimant was a non-smoker and indicated the presence of bilateral L5 and left S1 radiculopathy. Surgical intervention was recommended. The claimant underwent a psychiatric evaluation on 03/11/08 that noted the claimant had a history of smoking one pack per day, but quit after his first surgery and indicated the claimant was a candidate for surgery. Dynamic radiographs from 03/31/08 noted properly aligned L5-S1 in extension with 4.7 millimeter translation on flexion. Surgical intervention consisting of decompression and fusion from L4-S1 with bone grafting and instrumentation has been recommended.

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

ODG guidelines suggest that individuals are candidates for lumbar decompression who would have failed conservative care, would have imaging studies consistent with their clinical complaints and objective findings on exam. In cases where decompression is done in the face of relative instability particularly of dynamic instability on flexion/extension views and/or spondylolisthesis there are indications that decompression can be combined with surgical fusion based on the relative instability at that level.

In this particular case this gentleman has obvious signs of instability on flexion/extension views and a grade I spondylolisthesis at L5-S1. He also has evidence of recurrent disc herniation at L4-5 for which surgical treatment has been proposed. Records clearly document a failure of conservative care. Imaging studies document dynamic instability as outlined consistent with EMG's, which show findings of acute lumbar radiculopathy. Furthermore a psychological evaluation was completed to rule out any confounding issues from that standpoint that would preclude this gentleman from proceeding with surgery. All of the issues of this particular case appear to have been addressed in a reasonable fashion. The imaging studies are consistent with the clinical complaints. All confounding issues and variables have been discussed. This gentleman meets reasonable ODG criteria for proceeding with the surgical fusion and instrumentation in this setting. The reviewer finds that medical necessity exists for Decompression and Fusion @L4-S1 with bone graft and instrumentation.

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