

# I-Decisions Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW: OCTOBER 31, 2008**

**IRO CASE #:**

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

Lumbar laminectomy L4/5, L5/S1 posterior lateral fusion and instrumentation with three to four days length of stay.

### **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 does not exist for Lumbar laminectomy L4/5, L5/S1 posterior lateral fusion and instrumentation with three to four days length of stay.

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

The claimant is a xx year old female who was injured on xx/xx/xx when lifting a patient. Lumbar MRI report of 12/28/06 with and without contrast documented mild degenerative changes at L4-5 and L5-S1. There was no evidence of disc herniation or focal spinal stenosis. The neuro foramina appeared patent. The EMG/NCS report was not provided but the peer review of 08/27/08 indicated that an EMG/NCS of the lower extremities was done on 01/08/08 that was normal.

On 02/09/08 the claimant had an orthopedic evaluation with Dr. for persistent lumbosacral pain radiating to the lower extremities with paresthesias to the last three digits of the right foot.

Medications included Zanaflex, Ultracet, Celebrex and Lexapro. On exam the claimant had pain at L3 to S1 and along the right paravertebral area at the lower two facets and spasm, right greater than left. There was pain at the right upper SI joint and a positive straight leg raise to the right leg at 45 degrees. There was a positive Gaenslen and positive Patrick's and no motor or sensory deficits. Strength and reflexes were normal. The impression was lumbar strain/sprain; lumbar radiculopathy; lumbar facet dysfunction, anxiety and depression. Facet injections were recommended and Dr. felt the claimant would be a candidate for a trans-percutaneous fusion for her complete collapse of L5-S1 with right sided radiculopathy.

The claimant followed up with Dr. . The claimant was referred for another surgical opinion and seen by Dr. , neurosurgeon, on 07/22/08. On exam the claimant had no weakness; normal sensory exam and symmetrical reflexes. Leg raising test was positive on the right at 20 degrees and on the left at 30 degrees. There was tenderness in the low lumbar region. The impression was herniated discs L4-5 and L5-S1, the larger disc at L5-S1. Dr. reviewed the report of the 12/28/06 MRI and disagreed with the reading that indicated only moderate degenerative changes. He noted that the claimant had changes at L4-5 and L5-S1 which were significant but also had disc herniations at both of the levels that were significant. Dr. noted that the claimant had another MRI done that indicated the same findings of disc herniations at L4-5 and L5-S1. Dr. recommended laminectomy and foraminotomy with instrumentation at both L4-5 and L5-S1.

The surgery was denied on peer reviews of 08/05/08 and 08/27/08. Dr. indicated in appeal letters that the claimant continued to have low back pain radiating to the right leg and numbness to the toes on the right. He noted that she had been treated with physical therapy and pain management, epidural injection and trigger point injections. A new MRI was ordered which was also denied on peer review. In a letter dated 09/29/08 Dr. noted that the claimant was still having low back pain and right leg pain. Dr. again noted that the previous MRI in 2006 showed significant stenosis and herniation at L4-5 and another at L5-S1 to some degree. He felt the claimant was a candidate for surgery and needed a new MRI because the pain was increasing.

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

Lumbar laminectomy at L4-5 and L5-S1 with posterolateral fusion is not medically indicated and appropriate in this 53-year-old female.

The 2006 MRI does not demonstrate a significant neural compressive lesion. There have been no motor or sensory deficits documented within the medical records, and normal reflexes have been noted. There has been no instability, tumor, or infection. There have been MRIs which have demonstrated such findings, but they have been done in Mexico, and are not available for review.

Based upon this information, surgical intervention is not indicated and appropriate. The reviewer finds that medical necessity does not exist for Lumbar laminectomy L4/5, L5/S1 posterior lateral fusion and instrumentation with three to four days length of stay.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Lumbar: 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:**

- 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)