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Notice of Independent Review Decision

DATE OF REVIEW: 7/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient (2 day length of stay) lumbar spine surgery; lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, implantation of a bone growth stimulator at L4-5-S1

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.6	63030	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Practitioner notes/evaluations dated 5/19/09, 3/17/09, 2/26/09, 7/23/07

Electrodiagnostic Evaluation dated 6/25/09, 9/29/05

X-ray reports dated 7/11/05

Official Disability Guidelines provided-Low Back-Lumbar & Thoracic (Acute & Chronic)-Discectomy/laminectomy

PATIENT CLINICAL HISTORY:

The xx-year-old male sustained an injury on xx/xx/xx when he fell approximately 6 feet off a ladder with injury to his cervical and lumbar spine and right shoulder/arm.

MRI of the lumbar spine performed on 07/11/05 reported posterior and central herniation of the disc between L5-S1 of 3 mm causing displacement of the epidural fat. Posterior and central herniation of the disc between L4-5 of 4 mm was noted causing indentation of the anterior aspect of the thecal sac. Anterior bulge of the disc between L3-4 also was noted. Lumbar spine x-rays performed on the same date reported marginal spurs at the bodies of L5, L4 and L3.

Electrodiagnostic testing of 9/29/05 revealed an abnormal study with findings consistent with ongoing bilateral S1 and right L5 radiculopathy with left L5 radiculopathy, age not determined.

The patient was evaluated on 07/23/07. The patient reportedly had been treated conservatively with physical therapy, TENS unit, massage therapy, and 2 injections. It was determined the patient reached maximum medical improvement effective 08/15/06, and was assigned a 9% whole person impairment rating.

Psychological evaluation was performed on 02/26/09. It is noted that a chronic pain management program would be helpful. It is also noted that at some point a psychiatric consultation may be helpful because it appears the patient is becoming more and more depressed and feeling somewhat helpless. No assessment was noted of the patient's appropriateness as a surgical candidate.

The patient presented on 03/17/09 for evaluation. Chief complaints were lower back pain with bilateral sciatica, worse on the right than on the left, neck pain and bilateral upper extremity radicular symptoms worse on the right than on the left. Physical examination at that time of the back and lower extremity reveal positive spring test L4-5 and L5-S1. There was positive sciatic notch tenderness on the right, positive Fortin finger test on the right, and positive extensor lag. There was positive flip test bilaterally, positive Lasegue's' at 45 degrees, positive Bragard's, decreased knee jerk, and ankle jerk on the right, absent posterior tibial tendon bilaterally, paresthesias in the L5 and S1 nerve root distribution on the right, weakness of the gastrocnemius-soleus, EHL and tibialis anterior on the right.

The patient was seen in follow up on 05/19/09. It was noted that the patient has had cardiology clearance for surgery. L4-5 and L5-S1 decompression with stabilization and restoration of disc space height was recommended.

Electrodiagnostic evaluation on 06/25/09 reported evidence consistent with active denervation/reinnervation processes involving the right L5 and S1 nerves, as well as evidence of relatively inactive denervation process involving left S1 nerve.

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

In the Reviewer's opinion, the clinical information provided did not establish medical necessity for the proposed lumbar fusion with instrumentation at L4-5-S1; **2 day length of stay**. MRI from 2005 showed posterior and central disc herniations at L4-5 and L5-S1 indenting the anterior aspect of the thecal sac, but no definite nerve root compression noted and no evidence of stenosis or spondylolisthesis. The medical record lacked documentation of recent conservative care and a current physical/neurological examination. Reference is made to x-rays with flexion/extension views performed in 06/09, however, the radiology report was not provided. There is no objective evidence of instability of the lumbar spine to support the request for two level lumbar fusion.

References:

ODG Treatment Integrated Treatment/Disability Duration Guidelines, Low Back chapter, Online Version

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)