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Notice of Independent Review Decision

DATE OF REVIEW: 3/18/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Revision Posterior Spinal Fusion to Stabilize the Pseudoarthrosis at L5-S1

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

Certified by the American Board of Orthopedic 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			Upheld

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.

Surgery scheduling slip/checklist dated 2/11/09

Injured worker information form/patient profile

Consultation report dated 02/11/09

Electrodiagnostic study report dated 02/29/08

MRI report of the lumbar spine dated 03/20/08

Operative report dated 08/03/07

Procedure note dated 08/25/08 regarding spinal cord stimulation trial

Official Disability Guidelines cited but not provided-Low Back

PATIENT CLINICAL HISTORY:

The patient is a male whose date of injury is listed as xx/xx/xx. Records indicate the patient was loading pallets and injured his back. The patient has complaints of low back pain and lower extremity pain. The patient underwent surgery on 08/03/07 with L4-S1 decompressive lumbar laminectomy and transforaminal lumbar interbody fusion. The patient was treated with physical therapy and several injections post surgery without improvement. A spinal cord stimulator trial was performed on 08/25/08. Records indicate that the trial failed. Electrodiagnostic testing performed on 02/29/08 reported findings consistent with bilateral L5 radiculopathy and right S1 radiculopathy. MRI of the lumbar spine performed 03/20/08 revealed extensive post operative changes consistent with previous posterior fusions from L4-S1 and anterior fusion L5-S1. There is extensive enhancing epidural scar tissue surrounding the thecal sac at L5-S1. The patient was seen on 02/11/09 with complaints of low back pain and lower extremity pain. Physical examination at that time noted the patient to be 5'10" tall and 260 pounds. The patient had normal gait pattern with tandem gait pattern. The patient was able to toe and heel walk without difficulty. He has 5/5 motor strength testing in the upper and lower extremities. Sensation is grossly intact in the bilateral upper and lower extremities. No long tract signs are seen. There is good range of motion in the upper and lower extremities. There is tenderness to palpation about the region of L4-5, L5-S1, mostly at the L5-S1 level. The patient has pain with both flexion and extension which does reproduce his pain. It was noted that the MRI scan showed some epidural fibrosis about the L5-S1 segment where the patient had a previous laminectomy. The remainder of the intervertebral discs above this appears normal, and placement of the pedicle screws is seen within the pedicles L4-S1. The impression is low back pain secondary to pseudoarthrosis at L5-S1. The physician noted that on x-ray the patient has pseudoarthrosis with no bone formation seen in the interbody cage at L5-S1 with subsidence of the graft and revision posterior spinal fusion to stabilize pseudoarthrosis at L5-S1 was recommended.

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

In the Reviewer's opinion, based on the clinical information provided, the request for revision posterior spinal fusion to stabilize pseudoarthrosis at L5-S1 is not supported as medically necessary.

The patient underwent two level lumbar fusion at L4-5, L5-S1 in 08/2007. Subsequent MRI reported extensive post operative changes consistent with the previous fusion and also noted extensive enhancing epidural scar tissue surrounding the thecal sac at L5-S1. There is no documentation that an attempt has been made to address this enhancing epidural scar tissue by means of epidural steroid injection or possible adhesiolysis. There

Notice of Independent Review Decision
Page 3

is no objective documentation of pseudoarthrosis at L5-S1, although there were references to radiographs to demonstrate pseudoarthrosis. The patient's most current clinical examination performed on 02/11/09 revealed no neurologic deficits with normal motor and sensory examination.

References:

The Official Disability Guidelines, 13th edition, The Work Loss Data Institute.

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.](#))

**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)