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Notice of Independent Review Decision

DATE OF REVIEW: 11/9/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ALIF L4-5, L5-S1 with a one-day inpatient stay

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/adverse determinations 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	847.2	22558	Upheld
		Prospective		22585	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Determination letters dated 10/19/09, 10/27/09
 Physician/practitioner notes/letter dated 1/2/08, 2/12/08, 4/8/09, 5/6/09, 6/24/09,
 7/2/09, 10/12/09
 FCE report dated 2/26/09
 MRI/x-ray reports dated 5/27/09, 10/30/08
 Operative report dated 10/30/08

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PATIENT CLINICAL HISTORY:

The claimant sustained an injury on xx/xx/xx from a fall. A Designated Doctor evaluation dated January 2, 2008 noted low back pain with left lower extremity symptomology, that the claimant had been treated with epidural steroid injections, and that a determination of maximum medical improvement (MMI) had been made. The physician noted that there were two protruding discs and that there is no documentation of pre-existing changes. Additional evaluation was suggested. After obtaining additional imaging studies, it was the opinion of the Designated Doctor that the two level disc lesions pre-existed the date of injury, xx/xx/xx.

An evaluation approximately xxxx months later (April 2009) noted postlaminectomy syndrome and lumbar pain, and that maximum medical improvement had not been reached. This was based on a determination that there was instability, although this was not supported by the imaging studies completed, and back pain preventing reaching maximum medical improvement. By May this was labeled a chronic pain situation. Repeat radiographs noted no translation on flexion or extension studies. The Reviewer noted the two different MMI determinations.

Physician follow-up of 7/27/09 noted that the MRI indicated disc desiccation and post-operative granulation tissue. The physician's impression was "HNP with lumbar radiculopathy." The claimant was informed that a two-level lumbar surgery can be performed, and with that, there probably would not be resolution of all the low back pain.

Follow-up on 10/12/09 noted increasing low back pain and a referral for a two-level fusion procedure.

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

According to the Reviewer, as noted in the Division mandated Official Disability Guidelines Lumbar fusion surgery is "Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the

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selection criteria outlined in the section below". As noted on imaging studies there is no instability or translation.

Therefore as defined in the AMA Guides to the Evaluation of Permanent Impairment, 4th edition, without instability there is no basis for fusion.

The ODG also goes on to note that (*Lumbar fusion in workers' comp patients*: 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. Until further research is conducted, there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. (Fritzell-Spine, 2001) (Harris-JAMA, 2005) (Maghout-Juratli, 2006) (Atlas, 2006)

Lastly, we come to the "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. (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 preop, 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

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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. ZOO1) (BlueCross BlueShield, 2002)

Therefore, in the Reviewer's opinion, with no objectification of a spondylolithesis, no segmental instability, and no identified segmental failure there is no objective support for the requested procedure with a one-day inpatient stay.

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**

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- 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)**