



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165  
Ph 972-825-7231 Fax 214-230-5816

## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/7/2010

**IRO CASE #:**

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

The service under review is the medical necessity of a TLIF with decompression at L4/5; Rt L5/S1; laminectomy/hemilaminectomy with a two day LOS.

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

The reviewer is a Medical Doctor who is board certified in Orthopedics. This reviewer has been practicing for greater than 15 year and performs this type of service in practice.

### **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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a TLIF with decompression at L4/5; Rt L5/S1; laminectomy-hemilaminectomy with a two day LOS.

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

Records were received and reviewed from the following parties: Coventry, MD, and.

These records consist of the following: Coventry: 1/19/10 DWC 69 and report by, MD.

Dr.: 3/12/10 denial letter, 3/5/10 denial letter, 3/3/10 request for reconsideration, 2/23/10 preauth request, 2/16/10 progress eval by Dr., daily notes 2/23/10 by Dr., 2/8/10 psych evaluation, 4/19/09 lumbar MRI report, 4/6/09 lumbar radiographs, 11/12/09 lumbar MRI report, 9/8/09 procedure report and 5/06/09 to 5/14/09 notes by PT.

: letter – 4/1/10 and, Ph.D. amended Psych Eval report – 2/8/10.

We did not receive the WC Network Treatment Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was noted to be status post laminectomy at L4-L5 with repeat discectomy in 2004. The original mechanism of injury was moving a heavy crate resulting in a painful low back. Persistent low back pain with radiation into the bilateral thighs was noted. A chronic disc protrusion at L4-5 was noted on imaging studies, as was foraminal stenosis, a mass effect on the L4 nerve root, a disc herniation at L5-S1 and S1 nerve root displacement. The 4-19-09 dated MRI revealed facet arthrosis with bilateral L4 nerve root compression. At L5-S1, an annular tear was noted. A subsequent MRI report revealed S1 nerve root impingement with stenosis. A 1-9-10 dated Designated Doctor Report discussed a two level decompression and fusion. A 2-8-10 dated psychosocial evaluation denoted concerns about the claimant's lack of predictability to a proposed surgical intervention. Within the rationale of the denial letter, the reviewer indicated that if the psychological profile opinion was clarified and there was no contraindication for surgery, then the proposed procedures could be considered reasonable and necessary (including fusion, due to the potential for destabilization with additional decompression surgery.)

A prior 3-3-10 dated request for reconsideration letter discussed the psychosocial evaluation and the fact that the opinion expressed within did not appear to contraindicate surgical intervention as proposed. The AP's agreement with the designated doctor opinion was re-emphasized.

The 2-16-10 and prior AP progress notes were reviewed in detail. The patient's clinical deterioration, low back pain, weakness and numbness in the lower extremities were reiterated. Reference was made to the ODG-indication for fusion due to the prior multiple surgical interventions at 4-5 in particular.

The prior MRI reports were also reviewed as were the prior ESI procedure notes and therapy records.

The 3-23-10 dated letter from the claimant was reviewed. The 2-26-10 dated denial letter was reviewed. The 1 19 10 dated designated doctor evaluation was reviewed. The 2-16 dated AP consideration for surgical scheduling was noted.

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

Segmental instability has not been documented within the submitted records. This includes the lack of flexion-extension and/or other imaging evidence of objectively demonstrable segmental instability at the proposed levels of surgical intervention. Therefore, despite a possibility of surgically induced destabilization being associated with additional proposed multilevel decompression; fusion has not been documented to be reasonably required as instability has not been currently demonstrated. In addition, ODG criterion for fusion are still required in a case in which a spinal segment has been re-operated and nerve impingement has been documented. ODG criterion for fusion have not been satisfied, as noted above. Finally, the psychosocial opinion appears to reflect a less than optimal psychiatric milieu for the proposed multilevel surgical procedures (as per ODG Discectomy/Laminectomy criterion

3-C-3). This is also especially relevant in light of the apparent lack of complete fulfillment of the ODG-associated criteria for fusion).

### ODG Guidelines

#### 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).

(3) 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 pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. (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.

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.

#### ODG Indications for Surgery<sup>TM</sup> -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA

Guides, 5th Edition, page 382-383. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral quadriceps weakness/mild atrophy
  - 2. Mild-to-moderate unilateral quadriceps weakness
  - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
  - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
  - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
  - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
  - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
  - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
  - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
  - 3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education ( $\geq$  2 months)
- B. Drug therapy, requiring at least ONE of the following:

- 1. NSAID drug therapy
- 2. Other analgesic therapy
- 3. Muscle relaxants
- 4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

- 1. Physical therapy (teach home exercise/stretching)
- 2. Manual therapy (chiropractor or massage therapist)
- 3. Psychological screening that could affect surgical outcome
- 4. Back school (Fisher, 2004)

**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)