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Notice of Independent Review Decision

DATE OF REVIEW: 04/12/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Anterior Lumbar Interbody Fusion L5-S1 with one day inpatient length of stay

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

Texas Board Certified Orthopedic Spine
Practicing Neurosurgeon

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Psychological evaluation/initial interview 1/5/09 Dr..
2. MRI left shoulder 3/6/09.
3. MRI lumbar spine 6/2/09.
4. Consultation and radiology report 6/16/09 Dr..
5. EMG/NCV 6/23/09.
6. Follow-up office notes 11/17/09 and 1/13/2010 Dr..
7. Surgery scheduling slip/checklist and Injured Worker Information forms.
8. Utilization review determination 1/21/2010 Dr. regarding non-certification anterior lumbar interbody fusion L5-S1with one day inpatient length of stay.
9. Clinic notes 2/10/2010, 2/24/2010, 3/19/2010 Dr..
10. Reconsideration/Appeal of adverse determination 3/1/2010 Dr. upholding original determination of non-certification anterior lumbar interbody fusion L5-S1with one day inpatient length of stay.

11. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who reportedly sustained an injury on xx/xx/xx when she was taking the hose off between a disposal and a trailer and the hose hit her in the left shoulder knocking her back and twisting her around, injuring her lumbar area. MRI of the Lumbar spine dated 6/2/09 revealed a 4mm central and slightly left paracentral protrusion at L5-S1 narrowing the neural foramina; multilevel mild facet arthropathy. Electrodiagnostic interpretation by Dr. on 06/23/09 reported evidence of chronic bilateral L5 lumbar radiculopathy without evidence of acute denervation. Treatment to date is noted to include physical therapy, medications, and injections without significant improvement.

The employee was seen in consultation by Dr. on 6/16/09 with chief complaint of low back pain. Dr. noted that the employee felt a “needle in my low back” when this first happened and also had significant left shoulder pain. The employee reportedly had approximately 12 visits of physical therapy, massage, and one trigger point injection which helped significantly. Social history was significant for smoking a pack per day. Physical examination noted the employee to be a well-developed, well-nourished female in no acute distress. She is 5’3” tall and 140 pounds. She exhibits some mechanical low back pain when getting up from a seated position. She can ambulate normally without stooping or antalgia. She can heel and toe walk without difficulty. She has full range of motion of the lumbar spine, with increased pain on flexion. Straight leg raise is negative. She has negative Patrick’s and negative Stork test. She full strength in her lower extremities. Reflexes are 2+ and symmetric in the lower extremities. Sensation is intact. MRI scan was noted to show a very slight paracentral protrusion at L5-S1, going off to the left very slightly as well as into the neural foramen. Multilevel bilateral facet arthropathy also was noted. Impression was low back pain and the employee was recommended to undergo lumbar epidural steroid injection.

Progress note dated 11/17/09 reported that the employee is still having quite a bit of pain in her back radiating down her legs. She has not responded to conservative care. On 1/13/2010 the employee’s MRI was again reviewed, and Dr. felt the employee’s best option from the surgery standpoint is for an anterior lumbar interbody fusion at L5-S1.

A utilization review determination by Dr. on 07/07/09 recommended nonauthorization for ALIF L5-S1 with one day inpatient stay. Dr. noted that the employee did not meet ODG guidelines for the requested procedure. Dr. noted that imaging studies revealed mild degenerative change at L5-S1 with 4mm central and slightly left paracentral protrusion, with no evidence of nerve root impingement, and no evidence of instability of the lumbar spine on flexion/extension films. A psychological evaluation was noted to indicate issues that may complicate recovery from a surgical

procedure, and indicated that the employee may benefit from individual psychotherapy. Dr. further noted that the employee continues to smoke which is a negative factor toward a satisfactory surgical outcome. Also of relevance was the absence of objective evidence of neuromuscular impairment with normal motor and sensory exam, negative straight leg raise and intact symmetrical reflexes. Dr. found that surgical intervention would not be deemed to be medically warranted.

A reconsisderation/appeal request was reviewed by Dr., and the original determination was upheld. Dr. summarized the imaging studies, physical examination findings, and history of treatment. He determined that medical necessity for the proposed surgery was not established. He noted that there was no evidence of listhesis or instability of the lumbar spine on flexion/extension views. Dr. noted that the employee is a smoker. He also noted that there was no evidence of radiculopathy on physical examination, and the request for anterior lumbar interbody fusion L5-S1 is not indicated.

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

The clinical data presented does not support a determination of medical necessity for anterior lumbar interbody fusion with one day inpatient length of stay. The employee is reported to have sustained an injury when she hit in the left shoulder by a high pressure water hose causing her to twist her low back. MRI showed a 4mm central and slightly left paracentral disc protrusion at L5-S1 narrowing the neural foramina, but with no evidence of nerve root impingement. The employee did not respond to conservative care. There is no evidence of lumbar spine instability or listhesis. The employee has no neurologic deficit on clinical examination with normal motor, sensory, and reflex examinations, and negative straight leg raise. The employee also is noted to be a smoker which is a relative contraindication to lumbar fusion surgery. Accordingly, the previous denials should be upheld on IRO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines 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 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.)

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)