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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/08/2010
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-S1 lumbar fusion with 3-4 days inpt stay (63056, 63048, 22612, 22630, 20936, 38220, 95570, 22851, 22542)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopedic Surgeon

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

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
02/05/10 Review
03/10/10 Review
05/24/04 Employee Report of Injury
06/04/04 MRI Lumbar spine
03/29/05 DDE, Dr.
06/13/06 MRI Lumbar spine
06/19/06 office note Dr.
07/17/06 Operative Report Dr.
07/21/06 Discharge Summary Dr.
01/29/07 MRI lumbar spine
08/12/08 Hospital Consult Dr.
08/13/08 MRI Lumbar spine
08/14/08 Hospital Consult, Dr.
11/17/08 Office note Dr.
01/16/09 Office note Dr.
09/10/09 Office note Dr.
09/24/09 MRI Lumbar spine
09/24/09 MRI addendum:
11/17/09 Office note Dr.
01/07/10 Office note Dr.
Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- Fusion

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who reported a low back injury with radiation to the bilateral lower extremities on xx/xx/xx when he was cleaning up and moving items. The claimant was noted to be a non smoker with a significant history of three brain surgeries, cardiac bypass and Situs Inversus. He initially treated with chiropractic intervention. Lumbar MRI evaluation performed on 06/04/04 noted L3-4 and L4-5 disc protrusions with minimal indentation of the

thecal sac. A designated doctor evaluation conducted on 03/29/05 noted a treatment history of two epidural steroid injections (06/24/04 and 08/19/04), physical therapy, Ultram, unremarkable radiographs, chiropractic management, Neurontin, Klonopin, home exercises, pain management and normal electrodiagnostic studies on 01/06/05. Physical examination on 03/29/05 demonstrated normal gait; ability to heel and toe walk; lumbar tenderness, limited painful motion; positive bilateral straight leg raises; no radicular pain distal to the knees; no indication of cauda equina; strength of 5/5; and negative Waddell. The claimant was diagnosed with lumbar sprain and strain with lumbar radiculitis. The evaluating physician, Dr., felt the claimant was a maximum medical benefit and assigned an impairment rating of five percent.

The claimant had ongoing complaints of pain. Repeat MRI evaluation on 06/13/06 showed a transitional segment; multilevel degenerative disc disease; disc herniation to the left with associated central stenosis in the L5-transitional segment that extended into the left lateral recess, as well as facet degenerative changes and ligamentum flavum hypertrophy; and mild disc bulging at L4-5 with mild bilateral foraminal narrowing. The claimant was seen by Dr., neurosurgeon, on 06/19/06 with notation the claimant was still taking Plavix from recent cardiac surgery and they were waiting to wean from the Plavix to proceed with spinal surgery. There was mild left dorsiflexion weakness on physical examination. Lumbar radiographs noted the transitional segment with spinal stenosis at the L5-transitional level with facet arthropathy plus a large ruptured disc on the left with a fragment below the interspace. The claimant underwent bilateral laminotomy and foraminotomy at L5-transitional segment; removal of subannular extruded disc herniation at the L5-transitional level; and bilateral laminotomy and foraminotomy at L4-5 on 07/17/06. Intraoperative note indicated the claimant had developed claudication, had failed additional epidural steroid injections, had an onset of severe unremitting left sciatica on 05/17/06, had developed L5-S1 deficit with left plantar flexion weakness and had only been off the Plavix for five days preoperatively. The operative note also stated findings of thickening yellow ligament and considerable stenosis with performance of L5-transitional S1 left partial hemilaminectomy, medial facetectomy, complete foraminotomy and reference was also made to bilateral laminotomy and foraminotomy at this level; as well as L4-5 bilateral laminotomies and concentric narrowing of the canal that required “quite a bit” of foraminotomy to decompress the nerve. The surgeon indicated the surgery was “tedious” and there was difficulty with bleeding. An estimated blood loss of 300 milliliters was noted. Dr. also noted preoperative findings of left dorsiflexion weakness of -3’ left plantar flexion weakness of -1, decreased left ankle reflex and S1 sensory loss. The claimant treated with postoperative bracing and required intravenous pain control. He was started with physical therapy on postoperative day two and discharged on postoperative day four. It was reported he initially did well postoperatively, but then had recurrent pain.

A lumbar MRI on 01/29/07 demonstrated postoperative changes with a small fluid collection adjacent to spinous processes of L4 and L5 which could be related to surgery or seromas. Infection was not completely excluded. At L4-5 there was spinal canal stenosis due to protrusion and ligamentum flavum/facet hypertrophy and at least moderate stenosis. Postoperative changes were seen posteriorly with enhancing granulation tissue and fluid collections bilaterally, small on the left and 2 centimeters x 6 millimeters x 6 millimeters on the right. The left L5 was 1 centimeter. At L5-T there was a protrusion most notable in the paracentral and foraminal regions, mild bilateral foraminal narrowing, minimal bulges at L1-2, L2-3 and L3-4. The transitional segment S1 was normal.

Dr. saw the claimant on 08/12/08 as a hospital consult. The claimant was noted to have done well initially postoperatively, but reported periodic flare-ups of back and leg pain. “He had an epidural steroid injection a week and a half ago and did well. He conducted church services on Sunday (08/10/08), then woke with pain. Today while visiting a sick patient and putting his mother in the hospital he developed the sudden onset of chest pain, numbness in the arm and severe back and leg pain. He was neurologically intact without weakness and reflexes were present. He was sent to the emergency room.” Dr. stated that once the claimant was stable cardiovascularly he would be treated with medications and steroids for his back. It was felt that he would need a fusion sometime in the future. A lumbar MRI on

08/13/08 demonstrated L4-5 degenerative disc disease and moderate degenerative facet joints and hypertrophy of ligamentum flavum resulting in severe canal stenosis. Overall there was no significant change from prior. There was moderate narrowing and moderate circumferential bulging. At L5-S1 he had moderate narrowing, moderate circumferential bulging and moderate degenerative changes in the bilateral facet joints. There was no significant canal stenosis, mild to moderate multilevel degenerative changes at other levels in the thoracolumbar spine without significant canal stenosis. He had mild dorsal paraspinal edema right S1-2 presumably muscle strain, less prominent than previous 6 lumbar appearing vertebral bodies, L5 was transitional.

Dr. performed a hospital consult on 08/14/08 at which time his legs felt generally weak and with back spasm. Motor testing was somewhat limited by pain, but was essentially normal. Reflexes were 1-2+, he had focal tenderness and spasm at the lumbosacral junction and straight leg raise caused more back pain than a consistent radiating pain in either leg. He reviewed the MRI. Severe mechanical back pain with intractable spasm was diagnosed. Dr. indicated that once he had better pain control flexion/extension x-rays would be performed. He stated that no acute neurosurgical intervention was needed at that time. Dr. re-evaluated the claimant on 11/17/08 with ongoing pain in the right L5 facet area and reports of being very stiff in the morning. On examination he was focally tender in the right facet joint at L5, had decreased mobility, decreased painful flexion/extension, bilateral straight leg raise at 60 degrees with back pain, intact sensation and normal reflexes. Therapy and another facet injection were recommended. Dr. re-evaluated the claimant on 01/16/09 and he was no better. He stated he had to stop therapy due to pain. He stated when his back pain was worse, it went to the bilateral buttocks down past the thigh to the knees. His back was tight, had limited motion, positive bilateral straight leg raise at 70 degrees for back pain, intact sensation and normal reflexes on examination. Persistent back pain and facet arthropathy were diagnosed. Repeat facet injection and followup with Dr. were advised. They were trying to avoid a fusion. At the 09/10/09 followup the claimant reported no relief with epidural steroid injections or therapy. The claimant reported constant back pain which increased with stand, walk, bend and lift. He had predominantly back pain that goes down to the knees. Limited motion and positive straight leg raise for back pain at 50 degrees were noted. Reflexes were present without weakness. Chronic lumbar instability was added to his diagnoses. A stand up MRI with flexion/extension and consultation with Dr. were recommended. Dr. stated that despite the fact that surgery was trying to be avoided, the claimant was at the point where he needed something done.

A lumbar MRI on 09/24/09 demonstrated degenerative disc disease and bulging at L1-2, L3-4 and L4-5 and to a minimal degree at T11-12 and T12-L1. At L4-5 were wide laminectomies, greater disc space reduction and spondylosis lateralizing to the right. There was moderate foraminal stenosis on the right and mild on the left. Fibrovascular reaction in bone marrow adjacent to the endplates on the right, mild mass effect on the anterior and lateral thecal sac, greater on the left. At L3-4 there was bulging and facet with moderate ligamentum flavum hypertrophy resulting in moderate circumferential mass effect on the thecal sac, more marked in the subarticular lateral recesses. There was desiccation with moderate bulging superimposed on 4-5 millimeter broad left protrusion which contacted the left L3 root sleeve in the foramen. There was mild foraminal narrowing, greater on the right.

A superimposed moderate broad left lateral protrusion was also seen. There was relatively greater compression of the thecal sac with preservation of the cerebrospinal fluid around the intrathecal nerve roots during extension, moderate to marked loss of height, bulging with spondylosis lateralizing mildly to the right and a wide laminectomy. At L5-S1 the disc space was slightly smaller with no bulge or focal protrusion, hemisacralization of L5 on the right. At L1-2 there was desiccation with moderate bulging that mildly flattened the anterior thecal sac. At T11-12 and T12-L1: minimal bulging mildly flattened the anterior thecal sac. An addendum to the report noted greater compression of the thecal sac during extension.

Dr. saw the claimant on 11/17/09. It was noted that the claimant eventually had done well postoperatively, but began with worsening back pain, likely due to continued disc degeneration postoperatively and resulting in acquired stenosis. He stated that he had

intermittent epidural steroid injections with some relief in the beginning, but they had stopped working. The claimant reported primarily mechanical low back pain that radiated to a severe fashion into the right buttock and down the posterior leg to the foot, less pain in the left buttock. He had stopped working. The examination showed intact strength and sensation, straight leg raise with more increased mechanical back pain at 45 than radiating leg pain, but was worse on the right. It was noted that MRI showed postoperative changes, previous laminectomy at L4-S1, significant facet arthropathy causing severe lateral recess stenosis both at L4-5 and L5-S1 with disc collapse at both levels. Lumbar spinal stenosis with right lower extremity radiculopathy and severe disc degeneration at L4-5 and L5-S1 with intractable back pain were diagnosed. Dr. stated that the claimant had developed more acquired stenosis since the first surgery and disc degeneration had only progressed and was likely causing more of his mechanical low back pain in addition to the facet arthropathy. He felt the claimant was symptomatic from stenosis as well, especially on the right and has intractable pain. Dr. also stated the claimant was likely pain is intractable. He is likely facing additional emergency room visits, possibly hospitalization for intravenous pain medications unless he had definitive treatment which would involve a very wide decompression to take care of the lateral and foraminal stenosis which would likely destabilize his spine and he will need a reconstruction at the same time. He proposed decompression from L4-S1 with instrumented fusion and interbody arthrodesis as well as posterolateral bone grafts.

Dr. re-evaluated the claimant on 01/07/10 for daily back pain radiating into the right leg which was debilitating. Dr. stated that although the claimant does not have gross instability on dynamic MRI, he had significant lateral recess stenosis to warrant a wide decompression and was at a very high risk of developing instability and more often than not would eventually require instrumented fusion.

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

Based on ODG Guidelines the recommendation for the proposed lumbar fusion surgery from L4-S1 with three to four day inpatient stay is not medically necessary. This claimant is with low back pain. There is nothing to represent a progressive neurologic loss in this case as he is with full motor strength and full sensory function on the most recent physical exam findings. There is also nothing in the imaging studies since the time of his last operation to show any significant evidence of gross instability. Based on the clear lack of findings of the above the recommendation for proposed fusion surgery is not medically necessary from the information provided. The reviewer finds that medical necessity does not exist for L4-S1 lumbar fusion with 3-4 days inpt stay (63056, 63048, 22612, 22630, 20936, 38220, 95570, 22851, 22542).

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates; Low Back- Fusion

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 crtiteria) & 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)

Milliman Care Guidelines, Thirteenth Edition: Lumbar Fusion

Single level lumbar fusion, 3 day LOS- can be extended 1-3 days for multilevel, combo ant/ post, or extensive proc.

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

[ ] ACOEM-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[X] MILLIMAN CARE GUIDELINES

[X] 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)