

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 03/31/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Transforaminal Lumbar Interbody Fusion L4-L5 With 2-3 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 Surgeon

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. Physical therapy notes dated 06/16/09-07/08/09
2. Clinical note dated 05/18/09
3. Radiographs lumbar spine dated 05/29/09
4. Ultrasound abdomen dated 05/29/09
5. Radiographs lumbar spine dated 06/09/09
6. Urgent care notes dated 06/09/09-06/15/09
7. MRI lumbar spine dated 07/28/09
8. Clinical notes dated 08/05/09-08/27/09
9. Laboratory reports dated 09/01/09
10. Designated doctor's analysis letter from R.N. dated 09/02/09
11. Procedure note dated 09/14/09
12. Clinical note dated 10/28/09 and 11/17/09
13. Procedure note dated 10/13/09

14. Utilization review reports dated 12/16/09 and 01/27/10

15. Official Disability Guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was initially seen with complaints of back pain and blood in her stool. The employee stated her back pain developed after moving chairs at work.

The initial physical examination reported a negative digital examination for blood. The employee had full range of motion in the low back with increased pain noted on movement. No focal neurologic deficits are noted. The employee was prescribed Darvocet N-100 and Relafen 750mg.

Radiographs of the lumbar spine performed on 05/29/09 were normal.

Repeat radiographs of the lumbar spine on 06/09/09 appeared normal.

The employee was referred for physical therapy on 06/15/09 and continued physical therapy through 07/08/09. The employee did not have any significant relief of symptoms with physical therapy.

An MRI of the lumbar spine dated 07/28/09 reports central disc protrusion at the T11-T12 level with a far left lateral disc extrusion at L4-L5 producing severe left neuroforaminal stenosis.

The employee was seen by Dr. on 08/05/09 with continuing complaints of low back pain and radiating leg pain. Physical examination reported no evidence of neurological deficits. The employee was referred to a Dr. for epidural steroid injections.

It appeared the employee underwent a Designated Doctor evaluation in 09/15/09; however, no report was received for review, only an analysis letter by R.N.

The employee underwent a left L4-L5 transforaminal epidural steroid injection on 09/14/09.

A second injection was performed on 10/13/09.

Follow-up with Dr. on 10/28/09 stated that the employee did not receive lasting relief of symptoms.

Follow-up with Dr. on 11/17/09 stated the employee continued to experience pain despite two previous injections. The physical examination reported intact strength in the lower extremities with no sensation deficits. The employee was recommended for transforaminal lumbar interbody fusion at the L4-L5 level.

A utilization review report dated 12/16/09 did not recommend the request for a TLIF at L4-L5 as there was no evidence of severe structural instability or progressive neurological dysfunction.

A second utilization review report on 01/27/10 did not recommend the procedure, as there was again no evidence of a progressive neurologic dysfunction or severe structural instability.

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

The clinical notes provided for review do not support the request for a transforaminal lumbar interbody fusion. The radiographic reports submitted for review do not reveal evidence of any instability at the L4-L5 level that would be improved from the fusion procedure. The MRI study revealed evidence of a disc protrusion at the L4-L5 level with nerve root impingement; however, there were no findings on physical examination consistent with the MRI studies. The employee's physical examinations were unremarkable for any significant progressive neurologic deficit, which would otherwise indicate the procedure is medically necessary.

Given the lack of clinical documentation to support the procedure, the prior decisions are upheld.

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

Official Disability Guidelines, Online Version, Low Back Chapter

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](#))