



IRO#
5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100

DATE OF REVIEW: 12/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5 Posterior Lumbar Interbody Fusion with 5 day Inpatient Hospital Stay

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

This case was reviewed by a Texas licensed MD, specializing in Neurological Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
L4/5 Posterior Lumbar Interbody Fusion with 5 day Inpatient Hospital Stay	63047, 63048, 63075, 63076, RC111	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request	TDI	15		
2	Claim Dispute Notice		1	03/16/2010	03/16/2010
3	Diagnostic Test	MD	2	10/07/2009	10/07/2009
4	Diagnostic Test	MD	1	12/20/2005	12/20/2005
5	IRO Request	MD	4	11/02/2010	11/23/2010
6	Office Visit Report	MD	2	09/02/2010	09/02/2010
7	Peer Review Report	MD	13	03/10/2010	03/10/2010
8	Initial Request	Pre-Cert Referral Sheet	1	09/02/2010	09/02/2010
9	Initial Denial Letter		5	05/10/2010	11/12/2010

10	Claim Dispute Notice	PLN-11	1	03/16/2010	03/16/2010
11	Diagnostic Test	MD	2	10/07/2009	10/07/2009
12	Diagnostic Test	MD	1	12/20/2005	12/20/2005
13	IRO Request	TDI	5	11/02/2010	11/23/2010
14	Op Report	Imaging Center	5	12/09/2009	12/09/2009
15	Office Visit Report	MD	5	04/13/2010	09/02/2010
16	Peer Review Report	MD	13	03/10/2010	03/10/2010
17	Initial Request	Pre-Cert Referral Sheet	1	09/02/2010	09/02/2010
18	Initial Denial Letter		5	05/10/2010	11/12/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The records indicate that the claimant sustained a lifting injury to the low back. He has a remote history of prior right L4-5 decompression with far lateral microdiscectomy done on 7/19/2005. An MRI of the lumbar spine dated 10/7/2009 reported post-surgical changes; prominent hypointense focus fills the right L4-5 neural foramen with impingement of the exiting right L4 nerve root without associated enhancement, most likely represents extruded disc material from the right posterior disc margin; low grade scattered degenerative changes with multilevel mild disc bulging and mild facet arthrosis; mild/moderate multilevel neural foraminal stenosis; negative for central canal stenosis. The claimant was seen on 4/13/2010 and was reported as still having back pain and leg pain. Physical examination revealed well healed incision to his back. There was tenderness to palpation on the right side of the lumbar spine. Straight leg raise was positive on the right. There was decreased sensation and hypersensitivity in the L4 nerve root distribution. Strength was maintained. The claimant was noted to have failed conservative treatment consisting of physical therapy, epidural steroid injections and medications. He was recommended to undergo surgical intervention through a posterior lumbar interbody fusion technique. A utilization review determination dated 5/10/2010 non-authorized medical necessity for PLIF L4-5. The reviewer noted that there was no evidence of instability, and ODG does not recommend lumbar fusion when there are degenerative changes at more than 2 levels.

A utilization review determination dated 10/07/2010 non-authorized medical necessity for L4-5 posterior lumbar interbody fusion and 5 days inpatient stay. Clinical summary noted that the claimant was injured xx/xx/xx when he was squatted down while working. He lifted to move another compartment and developed back pain. MRI findings were reviewed. It was noted that the patient had undergone epidural steroid injection without relief. Physical examination on 9/2/2010 indicated tenderness to palpation of the right side of the lumbar paraspinal muscles, positive straight leg raise to the right, decreased sensation and hypersensitivity in the L4 nerve root distribution, strength and sensation were maintained. The reviewer noted that the claimant has no documented lumbar instability, and further noted that there was no psychosocial evaluation as per ODG guidelines.

A reconsideration review dated 11/12/2010 again determined non-authorization of medical necessity for L4-5 posterior lumbar interbody fusion with 5 day inpatient hospital stay. The reviewer noted that the patient has had a prior disc excision far lateral and now has a recurrent disc herniation at L4-5; however, the adjacent levels are not normal and any fusion at L4-5 would likely exacerbate these other disc levels. There was no psychological assessment completed, and no discussion regarding the claimant's tobacco use. The reviewer noted that a different surgery without fusion may be warranted. This is an IRO request for L4/5 Posterior Lumbar Interbody Fusion with 5 day Inpatient Hospital Stay.

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

Based on the clinical information provided for review, medical necessity is not established for L4-5 posterior lumbar interbody fusion with 5 day inpatient hospital stay. The claimant sustained a lifting injury to the low back on xx/xx/xx. His condition was refractory to conservative care including physical therapy and epidural steroid injections. On examination, straight leg raise was positive on the right with decreased sensation and hypersensitivity in the L4 nerve root distribution. There was no motor deficit in the lower extremities. Imaging studies revealed post-operative changes (patient has history of lumbar decompression in 2005) with multilevel degenerative changes and findings consistent with extruded disc at L4-5 with impingement of the exiting right L4 nerve root, and no evidence of central canal stenosis. There was no documentation of flexion/extension films demonstrating instability of the lumbar spine at any level. There also was no

indication that a presurgical psychological evaluation was completed to address confounding issues as per ODG guidelines.

It is noted that ODG guidelines provide that lumbar fusion is an option after two failed discectomies at the same level, but the records submitted reflect that the patient has had only one prior surgical procedure at the L4-5 level. As such, the proposed surgical procedure and inpatient stay is not indicated as medically necessary. The prior determinations correctly non-authorized medical necessity; the IRO upholds the prior determinations.

2010 Official Disability Guidelines, 15th Edition 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](#))

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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .