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Notice of Independent Review Decision

DATE OF REVIEW: 12/31/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Anterior Lumbar Fusion L4-5, Posterior Lumbar Decompression with Posterolateral Fusion and Pedicle Screw Instrumentation at L4-5

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

Texas Board Certified 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. Initial report 06/10/08 D.C.
2. Functional Capacity Evaluation report 06/11/08 D.C.
3. MRI lumbar spine 06/26/08.
4. Workers' Compensation form and health history 06/30/08.
5. Neurosurgical consultation report 07/07/08 M.D.
6. Lumbar myelogram with post myelogram CT 08/26/08.
7. Therapeutic intervention 10/02/08 transforaminal lumbar epidural steroid injection.
8. Progress note 10/10/08 M.D.
9. Therapeutic intervention 10/30/08 lumbar translaminar epidural steroid injection.
10. Progress note 11/13/08 M.D.
11. Follow up office visit note 11/17/08 M.D.
12. Prescription form 02/09/09 pre surgical screening/psych evaluation.
13. Facsimile cover sheet 02/09/09 regarding referral for psych evaluation.
14. Psychological evaluation 04/02/09 Ph.D.
15. Prior authorization request 04/20/09 regarding anterior lumbar interbody fusion at L4-L5, posterior lumbar decompression and posterolateral fusion with pedicle screw instrumentation at L4-L5.
16. Follow up office visit note 06/15/09 M.D.

17. Utilization review determination 07/10/09 regarding non certification anterior lumbar interbody fusion L4-L5, posterior lumbar decompression and posterolateral fusion, pedicle screw instrumentation at L4-L5.
18. Follow up office visit note 10/21/09 M.D.
19. Utilization review determination 11/13/09 non certification anterior lumbar interbody fusion L4-L5, posterior lumbar decompression and posterolateral fusion, pedicle screw instrumentation at L4-L5.
20. Expedited appeal/reconsideration of adverse determination 12/07/09 regarding non certification anterior lumbar interbody fusion L4-L5, posterior lumbar decompression and posterolateral fusion, pedicle screw instrumentation at L4-L5.
21. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is xx/xx/xx. Records indicate the employee was injured secondary to a motor vehicle accident in which he was the front passenger in a work vehicle that hit another vehicle that turned in front of his work vehicle. The employee complained of right knee, lower back, right shoulder and left leg pain.

An MRI lumbar spine performed on 06/26/08 revealed mild central canal stenosis and mild bilateral neural foraminal narrowing at L1-L2 through L3-L4 with protrusions at each level. At L4-L5, there was a broad 3-4 mm disc protrusion with severe multifactorial central stenosis and mild bilateral foraminal narrowing. At L5-S1, there was a 3 mm central disc protrusion with a zone of hyperintensity suggesting acute disc herniation associated with mild central canal stenosis. The employee initially was treated by D.C.

The employee was seen for neurosurgical consultation by Dr. on 07/07/08. Dr. noted that the employee described an acute onset of low back pain secondary to a motor vehicle accident and currently described a constant, deep stabbing pain with radiation mainly into the left lower extremity along the lateral thigh and calf and intermittently into the dorsum of the left foot with associated numbness and tingling in a similar distribution. The employee was noted to be status post physical therapy with no significant improvement in symptomatology. On examination cervical range of motion was full. Lumbar range of motion was decreased in forward flexion secondary to pain. Motor examination revealed 4/5 strength in the tibialis anterior and extensor hallucis longus muscle on the left, otherwise 5/5 throughout. DTRs were +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Gait was antalgic. The employee had difficulty with heel walking, less difficulty with toe walking, and no difficulty with tandem walk. Straight leg raise was positive on the left at 45 degrees and negative on the right. Sensory examination revealed a hypoesthetic region in the L5 and S1 distributions on the left to pinprick and light touch, otherwise intact. Coordination was intact. The employee was recommended to continue physical therapy for symptomatic relief and evaluation for epidural steroid therapy. CT myelogram was recommended to better evaluate foraminal stenosis at L4-5.

CT myelogram performed 08/26/08 revealed multi level changes with spinal stenosis at multiple levels. X-rays 5 views performed 08/26/08 revealed spondylosis with hypertrophic spurs at multiple levels, with mild disc height narrowing at L4-5 and L1-2.

The employee underwent lumbar ESIs on 10/02/08 and 10/30/08. The employee had no significant improvement in response to injections.

The employee was seen in follow up by Dr. on 11/17/08 who recommended anterior lumbar interbody fusion at L4-5 with posterior lumbar decompression and posterolateral fusion and pedicle screw instrumentation at L4-5.

The employee underwent psychological evaluation by Dr. Dr. determined there were minimal psychological factors present and concluded the employee to be a good surgical candidate.

Dr. saw the employee on follow up on 06/15/09 and continued to recommend lumbar fusion surgery.

There was a utilization review determination dated 07/10/09 by Dr. After summarizing the clinical notes and imaging studies, Dr. recommended non-certification of an anterior lumbar interbody fusion at L4-L5, posterior lumbar decompression with posterolateral fusion, and pedicle screw instrumentation at L4-L5. Dr. noted there was no evidence of spinal instability on imaging studies. He further noted that recent conservative care had evidently been minimal as there was none described in the recent office notes. The employee was not described as being active in home exercise program, and had not been involved in an intensive spinal rehabilitation program attempting to resolve the problem non-surgically. Dr. noted the employee had multilevel degenerative changes on imaging studies with no definite single level reported that could be definitely identified as the symptom generator. Dr. noted that attention should be given to active modes of rehabilitation treatment such as spinal rehabilitation program rather than subjecting the employee to a surgical procedure that has very little supported evidence based on literature.

The employee was seen by Dr. on 10/21/09. Dr. noted the employee returned with no significant improvement in symptomatology. Dr. noted he continued to feel the employee was a surgical candidate secondary to failure of conservative medical therapy including physical therapy and epidural steroid therapy, pain duration greater than six months, current neurologic status with evidence of severe spinal canal stenosis at L4-L5 with myelographic block, decreased disc height, disc desiccation, retrolisthesis of L4 and L5 approximately 3 mm with vacuum disc phenomenon and decreased disc height with associated nucleus pulposus approximately 4 mm with left sided foraminal stenosis.

A utilization review determination dated 11/13/09 by Dr. indicated that after summarizing the clinical notes and imaging studies, Dr. recommended non-certification of an anterior lumbar fusion at L4-L5, posterolumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-L5. Dr. noted there was no documentation of a diagnosis/condition (with report of subjective/ objective/imaging findings) for which fusion is indicated (such as instability) to support the medical necessity of lumbar spine fusion.

An expedited appeal/reconsideration determination by Dr. dated 12/07/09 recommended non-certification of the previously denied lumbar fusion surgery. Dr. noted there remains no documentation of a diagnosis/condition for which fusion is indicated.

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

Based on the clinical data presented for review, the request for anterior lumbar fusion L4-L5, posterior lumbar decompression and posterolateral fusion, pedicle screw instrumentation at L4-L5 is not seen as medically necessary. The employee is noted to have sustained injury as a restrained passenger in a motor vehicle accident. The employee underwent a course of conservative treatment including physical therapy and epidural steroid injections without significant improvement. Imaging studies of the lumbar spine revealed multilevel degenerative changes throughout the lumbar spine with varying degrees of spinal stenosis. Radiographs of the lumbar spine five views revealed degenerative disc disease, but there was no indication of instability of the lumbar spine at any level.

As noted by previous reviewers, there is no documentation of a diagnosis/condition for which fusion is indicated. Medical necessity is not established for the proposed surgical procedure.

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

The 2009 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition. 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)