

# I-Resolutions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/19/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Lumbar laminectomy and fusion L5/S1 with 2 LOS to include 22899, 63030, 63035, 69990, 62290, 22612, 22851, 20938, 22840, 22558, and 22325

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

M.D., Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates: Low Back – Spinal Fusion

Office notes, Dr. 09/10/09, 09/30/09

Office notes, Dr. 10/19/09, 10/20/09

Psychological Evaluation, Dr. Ph.D., 11/04/09

EMG/NCV, 11/23/09

Peer review, Dr. 12/14/09

Peer review, Dr. 12/23/09

Letters of Denial, 12/14/09 and 12/23/09

**PATIENT CLINICAL HISTORY SUMMARY**

This male sustained a lifting/straining type injury to his low back on x/xx/xx when he experienced a sudden onset of pain while moving appliances up stairs with 3 coworkers. Records revealed clinical instability at L5-S1 with herniated nucleus pulposus and radiculopathy that had failed to improve with conservative treatment. Dr. documented his review of an undated lumbar MRI that included an L5-S1 noncontained disc herniation rated as stage 3 with annular herniation, nuclear extrusion, disc desiccation and spinal stenosis. The orthopedic consult dated 10/20/09 noted complaints of back pain greater than bilateral leg pain. Lumbar x-rays revealed L5-S1 near bone-on-bone spondylosis and stenosis with facet subluxation, foraminal stenosis and retrolisthesis. The exam demonstrated marked paravertebral muscle spasms, tenderness, reflex and sensory deficits and motor weakness with positive provocation signs. A psychological evaluation completed on 11/04/09 determined the claimant to be a fair to good risk for surgical intervention with a diagnosis of adjustment disorder with depression and anxiety, secondary to his work injury. Bilateral lower

extremity EMG/NC studies completed on 11/23/09 demonstrated acute irritability in the bilateral L5 and S1 motor roots with additional findings on the needle study consistent with radiculopathy. Dr. requested authorization to proceed with a decompression discectomy and arthrodesis with restoration of his subluxation at L5-S1.

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

The requested decompression and lumbar spine fusion L5-S1 with two day length of stay is not medically necessary based on review of this medical record, as the requested surgery also includes request for intraoperative discogram, as well as open treatment and/or reduction of vertebral fractures. This is a gentleman with degenerative disc disease and a disc herniation at L5-S1, as well as EMG abnormality documenting radiculopathy. He has undergone conservative care and has had continued pain and symptoms for more than six months. This reviewer understands the need for laminectomy and decompression however it is not clear as to the absolute indication for surgery. While the lumbar spine x-rays appear to show some listhesis in extension, the psychological evaluation lists multiple issues to include adjustment disorder with depression, anxiety, and biosocial stressors, even though it says the claimant is a fairly good risk for surgery. The records are unclear as to why a discogram is being requested at the time of surgery and why open treatment for vertebral fracture is being requested since there is no evidence of a fracture. The reviewer finds that medical necessity does not exist at this time for Lumbar laminectomy and fusion L5/S1 with 2 LOS to include 22899, 63030, 63035, 69990, 62290, 22612, 22851, 20938, 22840, 22558, and 22325.

Milliman Care Guidelines® Inpatient and Surgical Care 13th Edition

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates: Low Back – Spinal Fusion

Spinal Fusion:

- Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction.
- Recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care

Spinal Fusion:

Pre-Operative Surgical Indications Recommended: 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 & 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.

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis.

- Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion.
- Unilateral instrumentation used for the treatment of degenerative lumbar spondylolisthesis is as effective as bilateral instrumentation.
- Patients with degenerative spondylolisthesis and spinal stenosis who undergo standard decompressive laminectomy (with or without fusion) showed substantially greater improvement in pain and function than patients treated nonsurgically.

For degenerative lumbar spondylolisthesis, spinal fusion may lead to a better clinical outcome than decompression alone.

**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

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)