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Notice of Independent Review Decision

DATE OF REVIEW: 01/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under review is a lumbar laminectomy Discectomy arthrodesis cages with posterior instrumentation.

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

The reviewer is a Medical Doctor who is a board certified Orthopedic Surgeon. This reviewer has been practicing for greater than 10 years. In the course of practice, this reviewer performs surgical procedures of a similar nature on a case by case basis.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a lumbar laminectomy Discectomy arthrodesis cages with posterior instrumentation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and Services Corp.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr: 10/20/09 report from C-IRO, office visit notes by Dr from 6/17/09 through 11/17/09, 11/2/09 lumbar radiographic report, 8/5/09 report by xxxxxx, LPC, 5/8/09 report by unknown Dr., 3/18/09 and 4/21/09 reports by MD, 4/20/09 electrodiagnostic report, 4/17/09 electrodiagnostic report and 4/29/09 report by xxxx, MD.

xxxxxx: 12/21/09 letter by, 11/24/09 denial letter, 12/2/09 denial letter and lumbar and thoracic ODG section.

We did not receive WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

In that review it was noted that the had low back pain with bilateral L5 radiculopathy and possible S1 radiculopathy. Dr had indicated that an MRI scan revealed a disc herniation at L5-S1 along with spinal stenosis. A decreased ankle reflex was noted on the left side. Parasthesias were noted in the L5 and S1 distribution on the left, along with muscle weakness of the gastroc-soleus and extensor hallucis. The diagnosis was herniated disk with radiculopathy and "clinical instability" with failure of non operative treatment. A fair prognosis resulted from the pre-surgical screen, however it was not felt to represent a psychological clearance by the reviewer. It was also not known if the claimant was a smoker, as per the reviewer. The reviewer also felt that the ODG guidelines were not satisfied regarding criteria for the use of a bone growth stimulator. The requested procedures were therefore not certified.

Notes from Dr from 11 17 09 (and prior) were then reviewed. "Facet subluxation on subsequent provided flexion-extension views were noted to reflect "clinical instability." The 8 5 09 dated "Pre-surgical screening" was then reviewed. The claimant "would do well to participate in individual psychotherapy pre-surgery...."

The 3 18 09 dated records from a Dr. were reviewed and revealed an annular tear at L5-S1. The electrodiagnostics from 4 20 09 were noted to reveal the findings as above. The 11 24 09 dated review was noted to reveal that the recent MRI report was not provided or available. It was also stated that the MRI from 10 08 didn't reveal instability or spondylolisthesis. The 12 2 09 dated adverse opinion letter after reconsideration request was reviewed was noted. It was noted that the report of the recent MRI didn't reveal nerve compression and the report of the flexion-extension films didn't reveal instability at the proposed surgical level of L5-S1. The electrodiagnostics were noted to not reveal definitive S1 radiculopathy. There was felt to be "no indication for fusion per ODG Guidelines."

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

There are multiple issues in this case that support a non-cert determination at this time. There is an apparent inconsistency between the clinical findings of S1 radiculopathy and the indeterminate electrodiagnostic findings of S1 radiculopathy. However, even allowing for the clinical findings of radiculopathy obviating the electrodiagnostics, as per ODG “when radiculopathy is already clinically obvious”, there are other issues. There is also an apparent discrepancy between the treating providers opinion of clinical instability at L5-S1 and the independent radiologist’s opinion of clinical instability only evident proximal to the L5-S1 level. The actual recent MRI report has not been provided for interpretation. Finally, the psychosocial evaluation reveals a fair prognosis and only with pre operative psychiatric sessions which have not been evidenced in this record. The smoking history has not been evidenced either. A bone stimulator may be reasonably required in certain instances of spine surgery (high risk cases such as refractory smokers in which a fusion attempt in itself may be non-indicated) in order to decrease the risk of pseudarthrosis. Neither nerve root compression nor clinical instability at the S1 level appears to have been consistently established and the psychosocial evaluation indicated that the claimant is not necessarily fully prepared for the procedures at present, pending additional treatment sessions as noted. Overall, surgical intervention itself has not been documented to be reasonably required at this time based on the preceding.

References: ODG Indications for Surgery -- Discectomy/laminectomy --
Required symptoms/findings; imaging studies; & conservative treatments below:
I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383 Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

Patient Selection Criteria for Lumbar Spinal Fusion:

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 & 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.

Criteria for use for invasive or non-invasive electrical bone growth stimulators:

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs.

This patient does not meet the criteria of the ODG or the reviewer's experience for a successful surgical outcome based upon the records provided. Therefore, the procedure is found to not be medically necessary at this time.

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)