

# Core 400 LLC

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Oct/04/2010

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

22558 Anterior Lumbar Fusion at L5-S1  
63090 Removal of Vertebral  
22845 Instrumentation  
22851 Prosthetic Device  
20936 Lumbar Autograft  
22630 Posterior Lumbar Fusion at L5-S1  
22612 Lumbar Discectomy/Foraminotomy at L5-S1  
63047 Removal of Spinal Lamina  
69990 Microsurgery Add-On  
22640 Instrumentation  
62351 Spinal Catheter  
20974 Electrical Bone Stimulation  
99221 Inpatient Hospitalization 3 Days

### 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)**

The reviewer finds that 22558 Anterior Lumbar Fusion at L5-S1; 63090 Removal of Vertebral; 22845 Instrumentation; 22851 Prosthetic Device; 20936 Lumbar Autograft; 22630 Posterior Lumbar Fusion at L5-S1; 22612 Lumbar Discectomy/Foraminotomy at L5-S1; 63047 Removal of Spinal Lamina; 69990 Microsurgery Add-On; 22640 Instrumentation; 62351 Spinal Catheter and 99221 Inpatient Hospitalization 3 Days is medically necessary.

The reviewer finds that 20974 Electrical Bone Stimulation is not medical necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, lumbar fusion, and bone growth stimulator

Office notes, Dr., 04/27/07

Lumbar spine X-rays, 04/27/07

MRI lumbar spine, 05/11/07

Office notes, Dr., 05/24/07

Office notes, Dr., 06/05/07, 06/25/07

Electromyography, 08/03/07

Lumbar myelogram, 08/08/07

DDE, Dr., 08/14/07

Operative report, Dr., 10/01/07, 11/12/07

RME, Dr., 02/20/08

Office notes, Dr., 05/11/09, 06/03/09, 07/16/09, 09/28/09, 12/11/09, 04/23/09, 07/29/10

RME, Dr., 07/20/09  
Biopsychological screening, 09/28/09  
Peer review, Dr., 08/24/10  
Peer review, Dr., 09/10/10

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is a female with complaints of low back pain radiating to her right lower extremity for a date of injury of xx/xx/xx. The 04/27/07 lumbar spine x-rays showed alignment and disc spaces normal, slight scoliosis, and no fracture or other significant abnormality. The MRI of the lumbar spine, dated 05/11/07, revealed degenerative disc disease associated with 5 millimeter central herniated disc at L5-S1 disc interspace and osteoarthritic changes of L5-S1. There was mild degenerative facet joint disease bilaterally at L5-S1.

On 05/24/07, Dr. stated that the lumbar spine x-rays showed spondylolysis, grade 1 lytic spondylolisthesis at L5-S1 that translated to 2-3 millimeter on flexion. The claimant was referred to pain management. On 06/25/07, the claimant underwent a right L5-S1 transforaminal epidural steroid injection.

The 08/03/07 electromyography showed lumbar radiculopathy involving the L5 nerve roots bilaterally which appear to be most significant at the right L5 nerve root level. The 08/08/07 lumbar myelogram showed subtle grade 1 spondylolisthesis noted at L5-S1 level. Lumbar myelogram was unremarkable.

The 08/08/07 CT of the lumbar spine revealed a L5-S1, 5.0 millimeter, grade 1 spondylolisthesis. There was no evidence to suggest spondylolysis but considerable degenerative arthritic changes were noted in the posterior facet suggesting that this represented a degenerative spondylolisthesis. There was no significant central or foraminal stenosis but there was evidence for a lateralizing disc bulge encroaching the inferior margin of the right foraminal recess at this level.

On 10/01/07, the claimant underwent S1 transforaminal epidural steroid injection and on 11/12/07, a L5 transforaminal epidural steroid injection was performed.

On 05/11/09, Dr. noted that the claimant had undergone six epidural steroid injections which helped the leg symptoms. The claimant reported using a cane for low back pain and right lower extremity pain. The claimant noted that her leg gave out. Examination revealed tenderness lower lumbar region with painful and decreased lumbar range of motion, straight leg raise positive on the right for leg symptoms and paresthesias along L5 on the right. Motor was intact. Dr. stated the MRI of the lumbar spine showed some annular tearing at L5-S1 with a grade 1 spondylolisthesis at that level.

Dr. followed the claimant through 07/16/09 and recommended a L5-S1 fusion. Dr. performed a required medical examination and agreed with the recommendation of surgery for the diagnosis of herniated nucleus pulposus L4-5 on the right and degenerative disc disease L4-5 bilaterally. A 09/28/09 BHI2 screening was performed. Treatment recommendations were; (1) if objective findings do not explain her disability, focus treatment on functional goals and encourage her to be more accountable to do what she can, (2) treatment should include medical interventions to decrease pain and psychological interventions to manage her pain and to increase her pain tolerance, (3) determine if objective medical findings corroborate her peak pain report. If so, use psychological support as needed during medical procedures, (4) If not, identify any psychological factors that could be contributing to her pain reports. On 12/11/09, Dr. recommended a discogram which was denied. Dr. evaluated the claimant on 04/23/10 and 07/29/10. The 07/29/10 examination revealed diminished sensation along right L5 distribution.

Extensor hallucis longus was intact. Reflexes lower extremities 2+ and symmetric. Dr. noted that the 12/15/08 x-rays of the lumbar spine showed 3 millimeter of translation between flexion and extension views of L5-S1 and that the MRI showed bulging at L5-S1 with far lateral foraminal stenosis. Dr. commented that the claimant had extensive physical therapy, six epidural steroid injections since 2007 and had unfavorable results from psychological testing. Dr. has recommended discectomy and fusion at L5-S1. Review of the records indicated that the claimant did not have sustained relief from the epidural steroid injections and has been treated with physical therapy, Skelaxin, Ibuprofen, off duty and narcotics.

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

The request for anterior lumbar fusion at L5-S1 with removal of vertebra is medically necessary. The claimant has L5-S1 spondylolisthesis, which by definition is unstable. She has failed conservative treatment. Posterior lumbar fusion at L5-S1 is medically necessary due to the fact there is a spondylolisthesis, which by definition is unstable, and the claimant has failed to respond to conservative treatment. Lumbar discectomy and foraminotomy would be medically necessary. And removal of spinal lamina would be a medically necessary part of this procedure. The use of a microscope would be medically necessary for the decompression and instrumentation would be medically necessary. Spine catheter for postoperative pain control would also be medically necessary. A three day length of stay following this procedure would also be medically necessary based on Milliman guidelines.

A bone growth stimulator would not be medically necessary due to the fact that the claimant has had prior surgery. It is only a grade 1 spondylolisthesis, and there was no documentation of tobacco use.

The reviewer finds that 22558 Anterior Lumbar Fusion at L5-S1; 63090 Removal of Vertebral; 22845 Instrumentation; 22851 Prosthetic Device; 20936 Lumbar Autograft; 22630 Posterior Lumbar Fusion at L5-S1; 22612 Lumbar Discectomy/Foraminotomy at L5-S1; 63047 Removal of Spinal Lamina; 69990 Microsurgery Add-On; 22640 Instrumentation; 62351 Spinal Catheter and 99221 Inpatient Hospitalization 3 Days is medically necessary. The reviewer finds that 20974 Electrical Bone Stimulation is not medical necessary.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, lumbar fusion, and bone growth stimulators

Lumbar 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 (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)

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. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003)  
Milliman Care Guidelines, Inpatient Surgery, 14th Edition

#### **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)