



Notice of

Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/01/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient L5-S1 360 Degree with Right Posterior Decompression

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Inpatient L5-S1 360 Degree with Right Posterior Decompression - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Progress Note, LOMC, 02/05/10, 02/10/10, 02/23/10, 03/23/10, 04/23/10, 06/02/10
- X-rays of the Lumbar Spine, M.D., 02/10/10
- MRI of the Lumbar Spine, , M.D., 02/15/10
- Evaluation, M.D., 04/27/10
- Post Injection Evaluation, Unknown Provider, 05/19/10
- DWC Form 73, LOMC, 06/02/10
- Evaluation, , D.O., 06/15/10, 06/16/10
- Correspondence, Dr., 06/15/10
- X-rays of the Lumbar Spine, , M.D., 06/30/10
- Myelogram Lumbar Spine CT, Dr., 06/30/10
- CT Guided Injection, Dr., 06/30/10
- Denial Letter, 07/27/10, 08/03/10
- Independent Medical Evaluation (IME), M.D., 08/11/10
- Pre-Operative Testing & Day of Surgery Orders, Unknown Provider, Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

On xx/xx/xx, the patient was replacing a propane tank on a forklift and felt a pop in her back. The low back pain was without radiation. She was initially seen at LOMC Clinic, and a lumbar and sacroiliac joint strain was diagnosed. She was treated with Motrin, Robaxin, and Lortab. A few days later, a lumbar spine series was performed which revealed a grade 1 spondylolisthesis at L5-S1

with a bilateral L5 spondylolysis and SI joint sclerosis. When evaluated at the clinic that day, the right SI joint strain was noted with lumbar spasm and back pain with numbness to the right lateral leg to her knee. She had trouble changing positions, and it was hard for her to lie down. Decreased range of motion and flexion limited to 25 degrees was noted with decreased sensation in the right lateral leg and foot with weak dorsiflexors. Toradol and Depo-Medrol were given.

An MRI scan was performed on 02/15/10. The MRI confirmed bilateral facet hypertrophy at L4-5, bilateral spondylolysis with Grade 1 spondylolisthesis of L5 on S1. No acute pars fracture was seen. There was mild bilateral facet hypertrophy with mild to moderate bilateral foraminal encroachment. There was no significant pathology above the L5-S1 level. *Nerve root compression was not noted.*

By 04/27/10, the patient had completed physical therapy. Her pain level was 6/10, with pain radiated to the right thigh and right buttock. She described this as burning, discomforting, numbness, sharp and shooting. Symptoms were aggravated by daily activities. Symptoms were relieved by injection (x2) and pain medications, currently reported to be Lortab and Zipsor. *Dr. noted normal neurologic and decreased range of motion with normal tone.*

The patient was then sent to Dr., an osteopathic neurosurgeon, with back pain and right lower extremity pain going to the midcalf on the right. The pain increased at night with weakness and numbness of the right noted. It was diffuse. A decreased right ankle jerk was noted with straight leg raising positive on the right. The angle at which it became so was not mentioned. Flexion/extension films were recommended.

A lumbosacral spine series was completed on 06/30/10 with findings of segmental instability at L5-S1 with anterolisthesis of L5 induced during flexion, and bilateral pars interarticularis defects at L5. During extension, there was a 6 mm anterolisthesis of L5 on S1, increasing to 9 mm during flexion. *This 3 mm slip does not meet the 4.5 mm slippage required by ODG Guidelines and AMA Guidelines 5th addition.*

A lumbar spine CT Myelogram with contrast was also perform on 06/30/10. Findings included bilateral pars interarticularis defects at L5 and Grade 1 anterolisthesis of L5 on S1 with the patient in the supine position. There was moderate bilateral neural foraminal stenosis at the L5-S1 level due to disc bulge and mild left convex lumbar spine scoliosis. The other lumbar spine disc levels appeared normal.

On 07/16/10, Dr. performed an independent medical evaluation on 08/11/10, both reviewing the case file and evaluating the patient for psychological evaluation prior to the recommended surgery. He did not feel that there was any psychiatric contraindication for surgery.

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

As outlined above, it is my opinion that at this time the medical records do not support that the patient has met the medical necessity requirements for Inpatient L5-S1 360 Degree with Right Posterior Decompression, based on the criteria of the ODG and AMA Guidelines as follows:

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
- AMA GUIDES 5TH ADDITION
- 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)