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Notice of Independent Review Decision

DATE OF REVIEW: 09/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior lumbar decompression with arthrodesis and instrumentation at L3-4 with 3-5 day stay

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

This case was reviewed by a Texas licensed DO, specializing in . The physician advisor has the following additional qualifications, if applicable:

AOA Neurological Surgery
 AOA Neurological Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Posterior lumbar decompression with arthrodesis and instrumentation at L3-4 with 3-5 day stay	22630, 22612, 22851, 22842	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		15		
2	Diagnostic Test	MRI L Spine	2	04/17/2008	04/17/2008
3	Office Visit Report	Rehab (DC)	6	04/11/2008	06/19/2008
4	Office Visit Report	MD	9	06/23/2009	06/23/2009
5	Office Visit Report	MD PA	24	11/12/2008	12/21/2009
6	Psych Evaluation	PhD & Associates	3	05/24/2010	05/24/2010
7	Initial Denial Letter		9	07/20/2010	08/03/2010
8	Archive		1	07/29/2010	07/29/2010
9	IRO Request	TDI-DWC	3	08/12/2010	08/13/2010
10	Archive		57	08/25/2010	08/25/2010

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a male whose date of injury is xx/xx/xx. Records indicate the patient was injured when he fell on a drain hole and hurt his left elbow, right hip and low back. The patient was noted to complain of low back pain that radiates to right leg. MRI of the lumbar spine dated 04/17/08 revealed mild disc desiccation and mild bulging annulus at L3-4, L4-5, and L5-S1. At L3-4, there is mild to moderate stenosis. At L4-5, there is mild stenosis, and at L5-S1, there is minimal stenosis. There is mild neural foraminal narrowing bilaterally at all 3 levels. Records indicate that the patient has been treated conservatively with physical therapy and epidural steroid injections, as well as medications. Examination by Dr. on 06/23/09 reported mild weakness of the legs and arms bilaterally possibly secondary to pain. Deep tendon reflexes were equal and symmetric. Gait was symmetric. Psychological evaluation on 12/21/09 noted the patient to be experiencing severe

depression and moderate anxiety. A chronic pain management program was recommended. The patient underwent psychological evaluation on 05/24/10 and seemed to have adequate understanding of surgery and reasonable expectation for it. A request for posterior lumbar decompression with arthrodesis and instrumentation L3-4 with 3-5 day stay was reviewed on 07/20/10, and the request was not approved. The reviewer noted lumbar MRI in 2008 showed some mild to moderate spinal stenosis at L3-4, but there was no report of radiculopathy. It was further noted that Designated Doctor placed the patient at MMI with 5% impairment rating for the low back. The patient was noted to be a smoker which is a relative contraindication to any fusion procedure. An appeal request for posterior lumbar decompression with arthrodesis and instrumentation L3-4 was reviewed on 08/03/10. The request was denied noting that the clinical documentation did not support the requested surgical procedure. The MRI study from 2008 was noted to not reveal any significant degenerative disc disease or motion segment instability at L3-4 level. Updated imaging has been recommended for lumbar spine, but no updated studies were submitted for review. It was also noted there were no updated evaluations regarding lumbar spine that provided rationale for requested surgical procedure. As such, medical necessity was not established. This an IRO referral for medical necessity for posterior lumbar decompression with arthrodesis and instrumentation at L3-4 with 3-5 day stay.

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

Based on the clinical information provided, the request for posterior lumbar decompression with arthrodesis and instrumentation at L3-4 with 3-5 day inpatient stay is not recommended as medically necessary. The patient sustained an injury to the low back in xx/xx. Most recent imaging study is MRI from 04/08 that revealed multilevel disc desiccation and mild disc bulging with mild to moderate stenosis at the L3-4 level. There is no evidence of focal disc herniation at any level, and no evidence of instability of the lumbar spine. No more recent imaging studies were submitted for review. There is no current physical examination report, with most recent physical examination from 06/09 revealing no motor, sensory, or reflex deficits. There was some mild weakness of the bilateral upper and lower extremities, but this appeared to be secondary to pain rather than a focal motor deficit. Given the current clinical data, medical necessity is not established and as such the prior denials are upheld.

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. ([Andersson, 2000](#)) 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

III. Conservative Treatments, requiring ALL of the following:

A. [Activity modification](#) (not bed rest) after [patient education](#) (≥ 2 months)

B. Drug therapy, requiring at least ONE of the following:

1. [NSAID](#) drug therapy
2. Other analgesic therapy
3. [Muscle relaxants](#)
4. [Epidural Steroid Injection](#) (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

1. [Physical therapy](#) (teach home exercise/stretching)
2. [Manual therapy](#) (chiropractor or massage therapist)
3. [Psychological screening](#) that could affect surgical outcome

4. [Back school](#) ([Fisher, 2004](#))

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
- 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)