

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthrodesis, Posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

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

This physician is a Board Certified Neurosurgeon with 43 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On July 1, 2008, M.D. performed a peer review. He determined that no further treatment, prescription medications, or diagnostic testing are reasonable and necessary for the work injury. She gets by with Tylenol #3. There is no indication for further treatment. The claimant's current medical status is one of chronic pain, after having undergone multiple surgeries.

On April 13, 2009, an MRI of the abdomen was performed. Impression: 1. Two gallstones. 2. No common ductal lesion inferior liver. Very likely to be a cyst. 3. Small parapelvic cysts or fluid filled calyces and mid left kidney. 4. No normal spleen. Small tissue in the left upper quadrant may be remnant spleen. Question prior splenectomy. 5. No other significant abnormalities as interpreted by Dr. M.D.

On April 13, 2009, an MRI of the thoracic spine was performed. Impression: 1. Mild degenerative disc changes in the lower thoracic spine with disc desiccation and minimal disc bulging. 2. No evidence of compression fracture. No thoracic spine mass or acute abnormality. No cord abnormality as interpreted by M.D.

On April 13, 2009, an MRI of the lumbar spine was performed. Impression: 1. Postoperative changes at L5-S1 without evidence of complication. 2. Degenerative findings at L2-3 through L4-5. Mild central stenosis L4-5. Bilateral recess disease, left more than right at these levels, most prominent at L4-5. Left posterolateral annular fissure at L4-5. Mild neural foraminal disease as discussed above, with bulging disc appearing to contact the undersurface of the exiting left L3 nerve root at L3-4 in distal left neural foramen as interpreted by M.D.

On April 27, 2009, the claimant was evaluated by, M.D. Impression: Thoracic degenerative disease. 2. L4-5 stenosis.

On May 22, 2009, the claimant was evaluated by, M.D. for an EMG of the bilateral lower extremities. She has a progressive history of lower lumbosacral back pain with pain left lower extremity paresthesia described as numbness and tingling. Impression: Abnormal electrodiagnostic study of the bilateral lower extremities showing positive electrodiagnostic evidence of a left L5 and S1 lumbosacral radiculopathy, which is both acute and chronic in nature. No evidence of other focal compression neuropathy, diffuse peripheral neuropathy, myopathy or plexopathy involving the bilateral lower extremities.

On October 22, 2009, a CT L Spine Post Myelogram was performed. Impression: 1. Anterior and posterior fusion attempt at L5-S1. I do not see solid bony fusion at this time, Interbody or posterior. Hardware is intact. 2. Otherwise, relatively mild multi-level degenerative spondylosis. The most significant narrowing is at L3-4 with 9 mm AP diameter thecal sac, mostly related to posterior element hypertrophy as interpreted by Peter Prokell.

On November 11, 2009, the claimant underwent a nuclear stress test. Impression: Myocardial perfusion imaging is without evidence of reversible ischemia. Overall left ventricular systolic function was normal without regional wall motion abnormalities.

On December 9, 2009, , M.D, evaluated the claimant. Impression: Degenerative disk and joint disease of the lumbar spine with spinal stenosis and pseudoarthrosis of the lumbar spine. Plan: Decompression and fusion of lumbar spine and revision and pseudoarthrosis.

On January 25, 2010, the claimant underwent a pre-surgical psychological evaluation. Psy.D. stated psychologically, there are no contraindications for spinal surgery.

On June 21, 2010, , M.D., a neurosurgeon, performed a utilization review on the claimant Rational for Denial: A revision surgery at L5-S1 is reasonable based on CT scan, however there are limited findings on the imaging studies that would

support the inclusion of L3-4 and L4-5. The prior denial was appropriate and should be upheld. Therefore, it is not certified.

On July 9, 2010, , M.D., an orthopedic surgeon, performed a utilization review on the claimant Rational for Denial: The imaging study fails to demonstrate significant pathology at L3-4 and L4-5 to warrant surgical intervention. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant claims she initially felt her problem had to do with her blood disorder. Her actual injury occurred when she took a short break and went to the restroom. Suddenly, she felt her right leg go lame and her whole right side went numb for about 30 seconds. She claims she grabbed a hold of the sink and was able to stand and did not fall to the floor.

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

The imaging studies submitted showed the claimant's prior fusion at L5-S1 failed to develop a solid bony fusion, however imaging studies failed to demonstrate significant pathology at the L3-4 and L4-5 surgeries to warrant surgical intervention; therefore, the previous decisions are upheld.

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)