



IRO#
5068 West Plano Parkway Suite 122
Plano, Texas 75093
Phone: (972) 931-5100

Notice of Independent Review Decision

DATE OF REVIEW: 03/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior Lumbar Interbody Fusion L4-S1, Partial Corpectomy L4, L5, 22558, 22585, Percutaneous Instrumentation L4-S1, 2 Day In Patient 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 Neurological Surgery. The physician advisor has the following additional qualifications, if applicable:

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
Anterior Lumbar Interbody Fusion L4-S1, Partial Corpectomy L4, L5, 22558, 22585, Percutaneous Instrumentation L4-S1, 2 Day In Patient Stay	22558, 22585, 63090, 22842, 22845, 20931	-	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		24	03/07/2011	03/07/2011
2	Diagnostic Test		2	01/26/2011	01/26/2011
3	Diagnostic Test		2	05/25/2010	05/25/2010
4	Diagnostic Test		1	01/07/2011	01/07/2011
5	IRO Request		1	03/07/2011	03/07/2011
6	Office Visit Report		6	11/10/2010	02/11/2011
7	Initial Denial Letter		15	02/08/2011	02/24/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX year old male who is reported to have sustained an injury to his low back on XX/XX/XX. It is reported on the date of injury that the claimant bent over to pick up an object weighing approximately 30-50 pounds. As he twisted to put the object on the table, he developed significant back pain. The records include an MRI of the lumbar spine dated 05/25/10. This study reports early facet osteoarthritis at L1-2, L2-3 and L3-4. At L4-5, there's a 6mm broad based disc bulge which indents the anterior thecal sac causing mild spinal canal narrowing although not considered quite stenotic. There's mild bilateral neural foraminal narrowing also due to disc bulge and hypertrophic facet osteoarthritic changes without definite neural impingement. At L5-S1, there's a 5mm right paracentral disc protrusion of facet osteoarthritis causing severe right neural foraminal narrowing. Disc bulge and spurring contact the exiting right L5 nerve roots in the neural foramen with potential impingement. There's disc desiccation with a

moderate loss of disc height. The disc bulge also indents the right lateral recess of the spinal canal and potentially contacts the right S1 nerve root.

On 11/10/10, the claimant was seen by Dr.. The claimant presents with low back pain. He's reported to have been tried on physical therapy, TENS, massage, as well as heat and ice without any relief. He's not had any injections. He denies any bowel or bladder issues. On physical examination, he's X'XX" tall and weighs XXX pounds. He's noted to have reduced lumbar range of motion. He has a negative straight leg raise bilaterally. Motor strength is graded as 5/5. Sensation is intact. His reflexes are 2/4 at the patella and 1/4 at the Achilles bilaterally. MRI is discussed. The claimant is diagnosed with lumbar spondylosis with disc protrusions at L4-5 and L5-S1. He subsequently is recommended to undergo lumbar discography at L4-5 and L5-S1.

On 01/07/11, the claimant was seen by Dr.. He is reported to have low back pain radiating down the right lower extremity. He is a one plus pack per day smoker. On physical examination, he complains of low back pain radiating into the right leg to the foot. He has a negative straight leg raise bilaterally. Hyperextension lumbar spine reproduces his back pain and his lumbar facets are exquisitely tender to palpation. Deep tendon reflexes are 2%2B/2+ bilaterally. Motor strength and sensation are symmetrical and appropriate. Dr. reports that these two large disc bulges have been associated with severe neural foraminal stenosis augers poorly for long term prognosis. He reports that the claimant is most likely going to require surgical intervention. He reports in an attempt to avoid such, he recommends lumbar epidural steroid injections.

On 01/26/11, the claimant underwent lumbar discography. This study notes a negative control disc at L3-4. At L4-5, the claimant is reported to have concordant back pain with abnormal morphology. At L5-S1, the claimant is again reported to have concordant pain with extravasation of contrast with degenerative facet changes.

On 02/08/11, a request was submitted for anterior interbody fusion L4-S1, partial corpectomy at L4 and L5 with percutaneous instrumentation from L4-S1 with 2 day inpatient stay. This request was reviewed by Dr.. Dr. notes on physical examination, there is negative straight leg raise bilaterally. Reflexes, motor and sensory are intact. He notes treatment has included medications, physical therapy and individual psychotherapy. He reported no documentation of associated clinical findings such as loss of reflexes, muscle weakness or atrophy of appropriate muscle groups, loss of sensation in corresponding dermatomes, and imaging showing instability at requested levels. He, therefore, opined it is not medically necessary.

On 02/09/11, the claimant was seen in follow-up by Dr.. Dr. reports that the claimant has undergone extensive conservative treatment and again requested a lumbar interbody fusion at these two levels.

On 02/11/11, the claimant was seen in follow-up by Dr.. He is noted to have diffuse tenderness to palpation, decreased range of motion of lumbar spine, negative straight leg raise bilaterally, and sensation is intact to light touch. Strength testing is 5/5. He noted discography is positive for concordant pain at L4-5 and L5-S1. He reported the claimant has failed conservative treatment. He again recommended performance of surgical intervention.

On 02/24/11, the appeal request was reviewed by Dr.. Dr. notes that the claimant has continued complaints of back pain. He notes diffuse tenderness bilaterally. There is decreased range of motion and negative straight leg raise bilaterally. Sensation is intact. He reports there is no clear documentation of conservative treatment. He notes no physical therapy progress notes were submitted for review. He further reported the claimant is noted to be a smoker, and there is no documentation of this being addressed. He further indicates the record does not contain any flexion or extension views to document spinal instability. This is an IRO request for Anterior Lumbar Interbody Fusion L4-S1, Partial Corpectomy L4, L5, 22558, 22585, Percutaneous Instrumentation L4-S1, 2 Day In Patient Stay.

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

The previous determinations are upheld. The submitted clinical records indicate that the claimant is a XX year old male who sustained an injury to his low back as a result of lifting and twisting on XX/XX/XX. The claimant has continued low back pain with reports of radiation into lower extremity. Conservative treatment to date per the clinical records consists of physical therapy, TENS, massage, and epidural steroid injections. The submitted clinical records do not include any supporting documents establishing the claimant has completed these conservative treatment options. Additionally, it is noted the claimant has degenerative changes of L4-5 and L5-S1. He has not undergone any lumbar flexion/extension radiographs establishing the presence of instability at operative levels. The claimant was subsequently referred for lumbar discography, which reports concordant pain at L4-5 and L5-S1. Per Official Disability Guidelines, lumbar discography alone is not to be utilized as isolated indication for performance of surgery. The record does not contain a preoperative psychological evaluation addressing all potentially confounding issues which could impact the claimant's recovery. The utilization review denials are consistent with ODG guideline recommendations. Therefore, the previous determinations 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](#))

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

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)

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with 28 TAC §12.206(d)(19), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on .