

AccuReview
An Independent Review Organization
(817) 635-1824 (phone)
(817) 635-1825 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: January 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 day inpatient lumbar laminectomy with fusion to the L5-S1 to include CPT Codes 99222, 630230-50, 63035-50x4, 22612, 22614x4, 20937, 37202-59, 11981-59, 20975.

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 48 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 November 1, 2010, the claimant was evaluated by M.D. An MRI revealed multilevel disk pathology with foraminal stenosis at L2-3 and L3-4. He had two

epidural Depo-Medrol injections with minimal benefit. Electrophysiologic studies were positive. Left hip x-ray showed minimal degenerative changes. He had a left hip injection. His primary problem is radicular pain into the left leg with numbness, dysesthesias and feeling of weakness. Straight leg raising is positive on the left. Left knee reflex is somewhat depressed. Little weakness of the left quadriceps. He has left antalgic gait.

On November 12, 2010, a lumbar myelogram was performed. Impression: Multilevel thecal sac deformity as interpreted by, M.D.

On November 12, 2010, a CT of the lumbar spine was performed. Impression: Prominent multilevel degenerative disk disease and spondylosis essentially at all levels as interpreted by M.D.

On November 29, 2010, the claimant was re-evaluated by M.D. He is getting worse. A lumbar fusion was recommended.

On December 13, 2010, x-rays of the lumbar spine were performed. Impression: Mild dextroscoliosis of the lumbar spine is noted. Mild to moderate narrowing of the L1-2 and L2-3 disk spaces and mild narrowing of the L3-4 disk space noted. Hypertrophic spurring is present involving the vertebral body endplates at L1-2, L2-3 and L3-4 levels. This is most pronounced at the L1-2 level. The oblique views demonstrate mild degenerative changes involving the facet joints. Lateral views of the lumbar spine obtained with flexion and extension demonstrate the vertebral bodies to maintain their alignment with flexion and extension as interpreted by M.D.

On December 16, 2010, the claimant was re-evaluated by M.D. He is having worse mechanical lumbar pain and bilateral radiating hip and leg pain, more so on the left, with numbness, dysesthesias, and weakness in the legs. He felt like the longer the surgery is delayed the more likely he is to have permanent neurologic deficit.

On January 10, 2010, the claimant was re-evaluated by M.D. His back and leg pain continues to get worse.

On December 7, 2010, M.D., an orthopedic surgeon, performed a utilization review on the claimant Rational for Denial: ODG Guidelines do not support lumbar fusion in the absence of instability. The claimant has no instability. ODG Guidelines would recommend a psychological screening which has not been undertaken. Therefore, it is not certified.

On December 22, 2010, , M.D., a neurosurgeon, performed a utilization review on the claimant Rational for Denial: Flexion/Extension films did not demonstrate any hyper mobility abnormality translation at any of the segments. The patient has multiple level abnormalities and that which occurred to him did not cause

these abnormalities, as they are primarily degenerative and stenotic in origin. A soft tissue injury occurred and if anything, the L5-S1 disc may have herniated there, however his symptoms do not go along with L5-S1. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

This male was injured on xx/xx/xx when he was lifting a heavy box.

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

There is no documentation of lumbar instability and no documentation that conservative care (i.e. Lumbar ESIs) has been exhausted. Therefore based on the ODG Guidelines the previous decisions are upheld.

Per the ODG Guidelines:

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](#).)

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)