

Notice of Independent Review Decision

DATE OF REVIEW:

05/31/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One day inpatient lumbar spine surgery, L4-5 L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages.

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

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.

The requested one day inpatient lumbar spine surgery, L4-5 L5-S1 lumbar laminectomy, discectomy, arthrodesis with cages is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Referral form
- 05/13/11 Referral
- 05/13/11 Notice of Assignment of Independent Review Organization
- 05/13/11 Notice Of Case Assignment
- 05/13/11 Letter from law office
- 05/13/11 Confirmation Of Receipt Of A Request For A Review
- 05/12/11 Request For A Review By An Independent Review Organization
- 05/11/11 Reconsideration/Appeal of Adverse Determination letter
- 05/03/11 Utilization Review Determination letter
- 03/08/11, 05/12/10, 05/11/10 Office Visit Notes, M.D.
- 02/03/11 Lower EMG and Nerve Conduction Study, M.D.
- 01/28/11 Behavioral Health Assessment, Clinic
- 12/07/10 Surgical Consultation, M.D.
- 11/17/10 office note, Clinic
- 10/06/10 Initial Evaluation, Clinic
- 04/28/10, 04/05/10 Inoffice Procedure Notes, Clinic
- 4/21/10 MRI lumbar spine
- 03/17/10 Follow-Up Note, Clinic
- 02/25/10 lab report, Clinic

- 02/23/10 New Patient Evaluation, Clinic
- Undated Pre-Authorization Request, M.D.
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a XX-year-old male who sustained an injury in XX/XXXX while working inside a large motor. Conservative treatment has consisted of medications, physical therapy, home exercise program, TENS unit, and epidural steroid injections with minimal relief. Electrodiagnostic studies revealed bilateral L5-S1 radiculopathy with involvement of S2-S4 motor roots. Psychosocial evaluation stated the injured individual was a good surgical candidate. Radiographs by clinician report demonstrated L4-L5 motion of 15 degrees and retrolisthesis of 7.5mm in extension. The injured individual reports smoking one quarter pack of cigarettes per day, and there is no documentation that he has completely stopped. Physical exam demonstrates findings of radiculopathy and weakness in the L5-S1 distribution.

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

The requested two level fusion is not medically necessary at this time. Relative angular motion is qualified as 20 degrees for instability. The injured individual's angular motion is documented as 15 degrees, which is less than guideline criteria. There is no radiology or MRI report submitted to confirm the clinician's reading. In addition, the injured individual is a smoker, and fusion is not supported for injured individuals who smoke.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Low Back Chapter – updated 5/24/2011

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, with 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. Spinal instability criteria includes

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).