

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: June 7, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; Lumbar.

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 40 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

February 25, 2010: M.D. evaluated the claimant. PE: Lumbar ROM was decreased in forward flexion secondary to muscle spasms. DTRs are

symmetrical. Sensory exam reveals no hypoesthetic region to pin prick and light touch. Impression: Status post lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L4-5 on the left for a previous history of lumbar radiculopathy.

March 29, 2010: M.D. re-evaluated the claimant. PE: Lumbar ROM was decreased in forward flexion secondary to muscle spasms. Motor exam reveals 5/5 strength throughout. DTR are symmetrical.

April 19, 2010: The claimant started PT.

July 12, 2010: M.D. re-evaluated the claimant. PE: Lumbar ROM was decreased in forward flexion secondary to muscle spasms. DTRs are symmetrical. Sensory exam reveals no hypoesthetic region to pin prick and light touch. Motor exam reveals 5/5 strength throughout.

July 21, 2010: Behavioral health assessment was performed. Impressions: Mixed Anxiety and Depressed Mood.

July 27, 2010: MRI of Lumbar Spine. Impression: Prior left laminectomy at L4-5. Recurrent left paracentral lateral disc protrusion and/or fibrosis suspected at L4-5 which contributes to moderate spinal canal and left lateral recess stenosis. Posterior annular fissure at L1-2. Mild to moderate bilateral foraminal stenosis at L4-5.

August 16, 2010: M.D. re-evaluated the claimant. PE: Lumbar ROM was decreased in forward flexion secondary to pain. DTRs are symmetrical. SLR was positive on the left at 50 degrees and negative on the right. Impression: Lumbar recurrent radiculopathy, Lumbar recurrent disc herniation at L4-5, Lumbar mechanical/discogenic pain syndrome at L4-5, Lumbago, and Status post previous lumbar microdiscectomy, laminectomy, foraminotomy, and partial facetectomy at L4-5 on the left.

September 14, 2010: X-Rays of Lumbar Spine. Impression: Marked narrowing of the intervertebral disc space at L4-5. There is no obvious subluxation of the spine. Anterior lipping is seen at L1 and L2 most prominently. There is no change in the alignment on flexion or extension.

January 10, 2011: M.D. evaluated the claimant. Medications: Refill Ultram, Flexeril, and Doxepin.

February 11, 2011: M.D. performed a Lumbar ESI and L5-S1.

March 31, 2011: M.D., a neurosurgeon, stated that lumbar interbody fusion L4-5 decompression is not medically necessary.

April 4, 2011: UR was performed. Rationale for Denial: The request is not medically necessary or supported by the available records. In the absence of instability the claimant does not meet medical evidence of instability at L4-5 level on imaging.

April 11, 2011: M.D. responded to with a Letter of Reconsideration. "I continue to feel this patient is a surgical candidate due to failure of conservative medical therapy, pain duration greater than 6 months, current neurologic status with evidence of recurrent disc herniation at L4-5 paracentrally and toward the left approximately 6 mm with severe left sided foraminal stenosis and left lateral recess stenosis."

April 25, 2011: UR was performed. Rationale for Denial: The records indicate there is no evidence of instability at the L4-5 level.

PATIENT CLINICAL HISTORY:

Employed as an xx.

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

The previous decisions are upheld, there is no documentation of instability per the diagnostic records provided; therefore, based on the ODG lumbar fusion is not indicated.

Per the ODG:

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.](#))

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)**