



DATE OF REVIEW: 03/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Laminectomy and Discectomy @ L4-5, L5-S1, Addtl Level, Microdissection Technique, Lateral Arthrodesis with Cage and Posterior Instrumentation @ L5-S1, Apply Spinal Prosthetic device, Autograft, Insert Spinal Fixation Device, Anterior Lumbar Arthrodesis @ L5-S1, Reduction of Subluxation Lumbar spine, Inpatient Hospitalization: 2 Days

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 MD, specializing in Neurological Surgery, Spinal Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic 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
Lumbar Laminectomy and Discectomy @ L4-5, L5-S1, Addtl Level, Microdissection Technique, Lateral Arthrodesis with Cage and Posterior Instrumentation @ L5-S1, Apply Spinal Prosthetic device, Autograft, Insert Spinal Fixation Device, Anterior Lumbar Arthrodesis @ L5-S1, Reduction of Subluxation Lumbar spine, Inpatient Hospitalization: 2 Days	63030, 63035, 69990, 22612, 22851, 20938, 22840, 22558, 22325, 99234	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Based on the clinical information provided, medical necessity is not established for the proposed surgical procedure with lumbar laminectomy and discectomy at L4-5 and L5-S1 as well as fusion with instrumentation at L5-S1. The patient sustained an injury to the low back in xx/xx. He was treated conservatively with therapy, medications, and epidural steroid injections without significant improvement. Electrodiagnostic testing revealed evidence of left S1 radiculopathy. MRI of lumbar spine showed disc protrusions at L3-4, L4-5 and L5-S1. At L3-4, there was an asymmetric left lateral disc bulge. At L4-5, there was a posterior central, left paracentral, and posterolateral disc bulge with left neural canal narrowing, bilateral facet hypertrophy and degenerative changes. At L5-S1 there was posterior central and right paracentral disc protrusion. There was no evidence of vertebral compression or spinal stenosis. Surgical consultation on 10/12/10 referenced x-rays of lumbar spine with flexion/extension views, but no radiology reports were submitted for review with objective evidence of motion segment instability. No presurgical psychological evaluation addressing confounding issues was documented. The most recent clinical report was from 10/10 with no subsequent updated report of the patient's current clinical status. The patient was noted to be a smoker and reportedly promised to stop smoking, but there was no documentation that the patient had actually initiated a smoking cessation program. Accordingly, the proposed surgical procedure is not indicated as medically necessary. The previous reviews correctly determined the request as non-certified. IRO recommends that the previous decisions be upheld.

Official Disability Guidelines Low Back Chapter, online version

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)