



Notice of Independent Review Decision

DATE OF REVIEW: 4/25/2011

IRO CASE # :

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 Day In-Patient Hospital Stay between 3/17/2011 and 5/16/2011

**1 Lumbar Fusion and Instrumentation at the L3-L4 Level
between 3/17/2011 and 5/16/2011**

**1 Purchase of Thoracic-Lumbar-Sacral Orthosis (TLSO) Back Brace
between 3/17/2011 and 5/16/2011**

1 one Fusion Stimulation between 3/17/2011 and 5/16/2011

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

M.D. whose specialty is Neurosurgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	4/06/2011
Confirmation of Receipt of a Request for a Review	04/04/2011
Utilisation Review Unit	04/06/2011
Initial Adverse Determination Letter	
Appeal Resolution Letter	03/17/2011
IRO Request Form from Patient	
Company Request for IRO form and Signed Confirmation	
M.D.	01/12/2006-3/14/2011

Clinical Notes to D.C.	
Hospital History and Physical Examination Radiology Reports Operative Report Discharge Summary	06/30/2006-08/30/2006 02/10/2006-07/01/2010 02/10/2006-06/30/2009 08/30/2006

PATIENT CLINICAL HISTORY [SUMMARY]:

Injured worker is a man. On xx/xx/xx, he was working in a ditch and was handed a full bucket of cement. He grabbed the bucket that was heavy and he had very severe pain in his low back with radiating pain down the hips and legs; the problem has persisted. He had all forms of conservative measures including chiropractic care, physical therapy, three steroid injections and chronic pain management. First doctor's note provided for this review was from M.D. dated 01/12/2006 where a lumbar Myelogram and post myelographic CT scan was requested and conducted on 02/10/2006. A multilevel discography was conducted on 6/30/2006. On 07/30/2006 Dr. note stated that the patient felt to be a good candidate for posterior L4-L5 and L5-S1 decompression fusion and instrumentation. The procedure was performed 08/30/2006 and the patient was discharged home 08/31/2006. His examination 02/21/2011 shows weakness of the quadriceps bilaterally and absent knee reflexes. An MRI of the lumbar spine from 07/01/2010 shows a disc bulge at L3-L4 causing bilateral foraminal narrowing. He is a smoker. The provider is requesting a lumbar fusion at L3-L4.

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

ODG criteria for lumbar laminectomy require nerve root compression, plus neurologic symptoms, plus trial of conservative treatments.

The proposed surgery is medically necessary. The claimant is symptomatic despite conservative measures from the foraminal stenosis at L3-L4. He has neurologic deficits related to this. Since the decompression is at adjacent level to a fusion, this level needs to be fused after decompression. As the patient is a smoker and considered at "high risk" for nonunion, a bone growth stimulator is medically necessary. A back brace is standard after a lumbar fusion.

ODG, "Low Back" chapter 16th Edition

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)

Criteria for use for invasive or non-invasive electrical bone growth stimulators:

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. ([Kucharzyk, 1999](#)) ([Rogozinski, 1996](#)) ([Hodges, 2003](#))

Back Brace, postoperative, fusion: Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. There is conflicting evidence, so case by case recommendations are necessary (few studies though lack of harm and standard of care). There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion for degenerative disease. Although there is a lack of data on outcomes, there may be a tradition in spine surgery of using a brace post-fusion, but this tradition may be based on logic that antedated internal fixation, which now makes the use of a brace questionable. For long bone fractures prolonged immobilization may result in debilitation and stiffness; if the same principles apply to uncomplicated spinal fusion with instrumentation, it may be that the immobilization is actually harmful. Mobilization after instrumented fusion is logically better for health of adjacent segments, and routine use of back braces is harmful to this principle. There may be special circumstances (multilevel cervical fusion, thoracolumbar unstable fusion, non-instrumented fusion, mid-lumbar fractures, etc.) in which some external immobilization might be desirable. ([Resnick, 2005](#))

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)