

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/20/11

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: L4-L5 posterior interbody fusion with cage/rod and screw system, 3 day  
Inpt stay (Reference #1060670)

63047, 22842, 22612, 22630, 22851, 20436, 20931, 77002, L0631

Start Date: End Date:

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

Texas Board Certified Orthopedic Spine Surgeon

## **REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. 09/10/09 - Initial Behavioral Medical Evaluation
2. 09/11/09 - MRI Lumbar Spine
3. 09/30/09 - Peer Review
4. 10/13/09 - Letter - M.D.
5. 10/22/09 - Electrodiagnostic Studies
6. 11/03/09 - Operative Report
7. 01/12/10 - Operative Report
8. 02/24/10 - Lumbar Myelogram
9. 02/24/10 - Post-Myelogram CT Lumbar Spine
10. 03/04/10 - Clinical Note - M.D., MBA
11. 03/16/10 - Peer Review
12. 04/27/10 - History and Physical - M.D.
13. 04/27/10 - Pain Drawing Assessment
14. 05/12/10 - Addendum - M.D.
15. 05/19/10 - Utilization Review
16. 05/21/10 - Designated Doctor Evaluation
17. 05/21/10 - Report of Medical Evaluation
18. 05/21/10 - Texas Work Status Report
19. 06/24/10 - Notice of Independent Review Decision
20. 09/20/10 - Clinical Note - M.D.
21. 12/28/10 - Behavioral Medical Evaluation
22. 01/11/11 - Clinical Note - M.D.
23. 02/11/11 - Lumbar Discogram
24. 02/16/11 - Clinical Note - M.D.
25. 02/21/11 - Utilization Review

26.02/23/11 - Addendum - M.D.  
27.03/01/11 - Utilization Review  
28. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a male who sustained an injury on xx/xx/xx while drilling holes through titanium and felt a pop in the low back.

The employee was seen for behavioral medical evaluation on 09/10/09. The employee reported sleep disturbance due to pain. The employee also reported difficulty with activities of daily living. There was pain with excessive sitting, standing, pulling, and driving. The employee's BDI score was 6, indicating minimal depression. The BAI score was 8, indicating mild anxiety. The employee's GAF score was 60. The employee was assessed with pain disorder associated with both psychological factors and a general medical condition, mood disorder due to a general medical condition, and sleep disorder due to a general medical condition. The employee was recommended for relaxation therapy training to address symptoms of pain, stress, and sleep disorder.

An MRI of the lumbar spine performed 09/11/09 demonstrated facet joint space narrowing noted bilaterally at L1-L2, L2-L3, and L3-L4. At L4-L5, there was a 2-3 mm broad-based disc protrusion present effacing the ventral epidural fat minimally narrowing the neural foramina about 15%-20% on both sides. Facet arthrosis was noted bilaterally. Anterior to posterior spinal canal measures about 11 mm. At L5-S1, there was 2 to 2 ½ mm broad-based disc protrusion present effacing the ventral epidural fat narrowing the neural foramina about 10%-15% on both sides. Facet arthrosis was noted bilaterally. Anterior to posterior spinal canal measures about 10 to 11 mm.

Electrodiagnostic studies performed 10/22/09 were abnormal with evidence suggestive of a bilateral S1 radiculopathy and left S1 radiculopathy. The employee underwent L5-S1 interlaminar epidural steroid injection on 11/03/09.

The employee underwent L5-S1 interlaminar epidural steroid injection on 01/12/10. Lumbar myelogram performed 02/24/10 demonstrated a moderate ventral epidural defect at L4-L5, suggesting a disc bulge/protrusion producing thecal compression but no central stenosis. No other lumbar disc herniation or abnormality was seen. There was slight accentuation of the lumbar lordosis.

Post-myelogram CT of the lumbar spine performed 02/24/10 demonstrated a 3 mm right posterior paracentral broad-based disc bulge/protrusion at L4-L5 which slightly compresses the adjacent thecal sac. There was no stenosis. At L5-S1, there was no disc herniation, central spinal or neural foraminal stenosis. There was mild accentuation of the lumbar lordosis. There was no spondylosis or spondylolisthesis. There was no paraspinous or intraspinal mass lesions noted.

The employee saw Dr. on 03/04/10. Physical examination revealed full strength of the bilateral lower extremities. Tension signs on the sciatic nerve were negative. The employee was assessed with L4-L5 internal disc derangement. The employee was recommended for lumbar discography followed by lumbar spinal reconstruction.

The employee saw Dr. on 04/27/10 with complaints of low back pain with radiation to the left testicle and left proximal thigh. The employee denied bowel or bladder dysfunction, but reported difficulty obtaining erection. Prior treatment included physical therapy and two epidural steroid injections with temporary minimal relief. The employee ambulated normally. The employee was able to heel and toe walk without difficulty. There were no muscle spasms noted. Lumbar range of motion was limited. There was pain with sitting straight leg raise bilaterally. Radiographs of the lumbar spine were noted to demonstrate moderate L4-L5 narrowing. The employee was assessed with L4-L5 discogenic pain. The employee was recommended for lumbar discography.

The employee was seen for Designated Doctor Evaluation on 05/21/10. The employee complained of pain, numbness, pins/needles, and tingling in the lower back. The pain radiated to the groin area. The employee reported erectile dysfunction and poor urinary stream with dribbling. Physical examination revealed tenderness to palpation of the lumbar spine. Palpation of the paravertebral muscles revealed spasms. Straight leg raise was positive bilaterally. Lumbar range of motion was decreased with pain. There was decreased sensation at L4. The employee was able to walk on the heels and toes without difficulty. The employee was assessed with lumbar radiculopathy. The employee was placed at Maximum Medical Improvement (MMI) and assigned a 10% whole person impairment.

The employee saw Dr. on 09/20/10 with complaints of low back pain with radiation to the left testicle and left proximal thigh. The employee denied bowel or bladder dysfunction, but reported difficulty obtaining erection. Prior treatment included physical therapy and two epidural steroid injections with temporary minimal relief. A physical examination was not performed. The employee was assessed with L4-L5 discogenic pain, L4-L5 internal disc derangement, and lumbar radiculopathy. The employee was felt to be a candidate for a L4-L5 fusion.

The employee was seen for behavioral medical evaluation on 12/28/10. The employee reported difficulties with activities of daily living. There was pain with excessive sitting, standing, pulling, and driving. The employee reported financial issues due to his work injury as he was struggling to pay his bills. The employee also reported anxiety and worry due to his pain. Current medications included Lotrel, Cymbalta, Robaxin, and Hydrocodone. The employee's BDI score was 20, indicating moderate depression. The employee's BAI score was 10, indicating mild anxiety. The employee's GAF score was 57. The employee was assessed with pain disorder with both psychological factors and a general medical condition and mood disorder due to a general medical condition. The employee was recommended for relaxation therapy training to address symptoms of pain, stress, and sleep disorder.

The employee saw Dr. on 01/11/11. Physical examination revealed tenderness in the lumbar region at the midline. Lumbar range of motion was limited. Straight leg raise provoked localized back pain. Ambulation was noted to be antalgic and stiff. There was normal sensation except for some decrease on the left lateral thigh. The employee was assessed with L4-L5 discogenic pain. The employee was recommended for discography.

Lumbar discography at L3-L4, L4-L5, and L5-S1 was performed 02/11/11. Injection at L4-L5 reproduced severe concordant back pain. The disc was shown to be degenerative and to have a posterior central annular fissure and leak of contrast material on discographic images. There were possible early internal degenerative changes of the L5-S1 disc without annular abnormality. The L3-L4 disc was normal.

The employee saw Dr. on 02/16/11. The discogram results were reviewed. Physical examination was not performed. The employee was assessed with L4-L5 discogenic pain. The employee was recommended for L4-L5 posterior interbody fusion with cage/rod and screw system. The note stated the employee had completed the required preoperative psychological evaluation.

The request for L4-5 Posterior Interbody Fusion with cage/rod and screw system, 3 day inpt stay was denied by utilization review on 02/21/11 due to lack of documentation regarding recent conservative treatment. There was no evidence of motor deficit on clinical examination. There was no instability reported on flexion/extension views. There was no psychological evaluation provided clearing the employee's for surgery.

The request for L4-5 Posterior Interbody Fusion with cage/rod and screw system, 3 day inpatient stay was denied by utilization review on 03/01/11 due to no evidence of instability. Also, reference was made to psychological evaluation but no report was provided.

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

The requested L4-5 Posterior Interbody Fusion with cage/rod and screw system, 3 day inpatient stay is not recommended as medically necessary. There is no evidence on imaging studies of significant disc space collapse, spondylolisthesis, or motion segment instability that would warrant lumbar fusion. The employee did have epidural steroid injections completed in 2009 and 2010; however, there is no documentation regarding any recent conservative treatment. Additionally, the psychological evaluation provided for review did not discuss the employee's requested surgical interventions or determine that the employee is an appropriate candidate psychologically. As the clinical documentation does not meet guideline indications for the request, medical necessity is not established.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

**Official Disability Guidelines, Online Version, Low Back Chapter**

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).