AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: MAY 23, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Laminectomy L2/L3-L3/L4, TLIF L4/L5

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

This physician is a Board Certified Orthopedic Surgeon.

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

On July 16, 2010 there is a radiology report dictated by MD, an MRI of the lumbar spine with and without gadolium. The findings state there vertebral body height is normal throughout the lumbar spine. There is also normal alignment without spondylolisthiasis. The conus medullaris, cauda equine and visualized distal nerve roots are normal. The impression states moderate central canal

stenosis at L4-L5 as described above. Mild to moderate bilateral foraminal stenosis is associated; moderate central canal stenosis at L2-L3, there is associated foraminal narrowing without overt foraminal stenosis; postoperative changes L4-L5 without complicating process, there is no pathologic enhancement status post gadolinium.

On December 16, 2010 there is a radiology report. The document submitted is illegible.

On January 7, 2011 there is a report by MD. the physical exam states claimant walks with an antalgic gait, is unable to stand on her right lower extremity, unable to walk on her heels and toes, motor exam of lower extremities demonstrates at least 4/5 power in all groups tested, reflexes are 1+ at all patella and Achilles, straight leg raise was negative, range of motion right hip limited.

On January 10, 2011 there is a radiology report for right hip read by 2 views. The findings state no evidence of fracture, avascular necrosis, osseous destructive lesion, or subluxation. The soft tissues have a normal appearance. Inferior and superior pubic rami appear normal. The impression states no acute abnormality.

On January 10, 2011 there is a radiology report for AP pelvis read by. The findings state AP view of the pelvis demonstrates a normal appearing sacrum, sacroiliac joints, iliac crests, acetbulae, proximal femurs and soft tissues. There is no visible fracture, mass, or destructive lesion. The impression states no significant abnormality demonstrated.

On January 10, 2011 there is a radiology report for lumbar spine 5 views read by. The findings state there is no evidence of acute fracture or abnormal subluxation. Multilevel osteophyte formation is present most pronounced in the lower lumbar region. The impression states spondylosis otherwise without acute osseous abnormality.

On January 12, 2011 there is a return visit appointment visit with MD. The report states in the physical examination the claimant's physical examination is not changed

On January 24, 2011 there is a request for precertification to for Laminectomy L2/L3-L3/L4, TLIF L4/L5 the diagnosis states stenosis. The request is made by Dr..

On January 27, 2011 there is an UR Denial by PA –HCN (TX) letter from Company to Spine Specialists, MD. The analysis and clinical basis for conclusion: the request for laminectomy at L2-3, L3-4 and transforaminal lumbar interbody fusion at L4-5 is not recommended as medically necessary. The claimant presented with low back pain with decreased motor strength on the

lower extremities. MRI showed mild to moderate foraminal and canal stenosis at L4-L5, foraminal narrowing at L2-3 and post surgical changes at L4 through S1. However, lumbar radiographs obtained on 1/10/11 demonstrated limited lumbar mobility with no gross instability. A pre-operative psychological evaluation was not provided in the reports. The patient is a known diabetic who smokes half a pack of cigarettes per day. As there is no documented plan for (1/27/11 6:12:21 PM) smoking cessation and blood glucose control, the surgical procedure cannot be justified at this time due to inherent risk of a less than favorable outcomes. Moreover, there is no indication in the records that validates exhaustion of appropriate conservative care including physical treatments, optimized pharmacotherapy and home exercises to warrant surgical intervention. Hence, this request is not certified. Attempts were made to reach the provider but were unsuccessful. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered. Addendum: I discussed the case with Dr. on 1/27/11 at 11:42 AM CST. The doctor confirmed that a psych eval has not been done. There is no change in determination.

On February 7, 2011 there is a follow up office visit note by, MD. The note states the physical examination has not changed. The note states will proceed with a psychological evaluation, including the MMPI-2-RF testing.

On March 2, 2011 there is a psychological evaluation by MEd, LPC. The conclusion states based on the clinical interview and objective testing performed during this assessment on 3/2/11 there are no significant contraindications for surgery at this time. She presents with an overall normal mental status with mild symptoms of anxiety and minimal depression are viewed as physiologically based. The claimant has a clear understanding of the pending surgical procedure, realistic expectations and a well established support system through recovery.

On March 7, 2011 there is a follow up progress note by MD. The HPI states the claimant has been cleared for surgery from a psychological standpoint with an overall normal mental health status with mild symptoms of anxiety and minimal depression. The claimant's physical examination are not changed. The plan states the claimant did recently have a debridement of what she calls a blood blister about her left foot and ankle, this would need to be resolved prior to surgery.

On March 17, 2011 there is a request for precertification to for Laminectomy L2/L3-L3/L4, TLIF L4/L5 the diagnosis states stenosis. The request is made by Dr..

On March 24, 2011 there is a letter of UR Recon Uphold-HCN (TX) to Spine Specialists. Under the conclusion it states: I was not able to speak with Dr. In this case, pain or sensory complaints following a physiologic or dermatomal pathway have not been documented. There was no evidence of a neurocompressive lesion either on the claimant's CT myelogram or the MRI as

outlined above. There was no objective evidence of L3 root compression and no documentation of mild to moderate unilateral quadriceps or anterior tibialla weakness. The report of the claimant's weakness of 4/5 in all groups tested would not be physiologic evidence of radiculapathy. Additionally, the claimant's reflex testing was unremarkable. No sensory dermatomal loss was noted. There is no documentation of segmental instability as there was no inclusion of flexion/extension lumbar study. With regard to conservative care, the record indicated that she had injections, as well as physical therapy; however, specifics of the treatment were not indicated. The clinical information as noted above does not satisfy ODG criteria and therefore, the request of laminectomy L2-3, and L3-L4 and a TLIF at L4-5 cannot be considered medically necessary. Because an adverse determination for the surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical history significant for cardiac bypass surgery, cardiac disease, TIA, diabetes, surgical history significant for 2 vessel bypass, hysterectomy, lap band, lumbar surgery x 2. Smokes ½ packs of cigarettes per day.

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

The proposed surgical procedure is not indicated at the present time; therefore the previous decisions are upheld.

1. Laminectomy: The MRI report of July 2010 documents moderate facet hypertrophy with ligamentum flavum thickening at L2-3. The stenosis is moderate and does not completely efface the CSF. There is no stenosis at L3-4. Moderate-to-severe central canal stenosis is reported at L4-5.

a. A laminectomy at L3-4 is not indicated. Although the MRI identified moderate-to-severe facet joint hypertrophy, there is no central or foraminal stenosis at this level.

b. At L2-3, there may be an indication for decompression, but there no evidence of that the stenosis is symptomatic at this level. Ideally a steroid injection at L2-3 would improve the claimant's leg symptoms. However, we do not have the specific details of the injection sites and their effects on the claimant. An EMG/NC study could identify which nerve roots are specifically affected.

c. The central stenosis at L4-5 may also need to be addressed at the time of surgery with a decompressive laminectomy.

2. TLIF L4/5: The MRI report of July 2010 disc dehydration and disc height loss at L4-5.

a. The medical record does not indicate whether the L4-5 disc is the source of the claimant's back pain. If the pain generator is the L4-5 disc, an epidural steroid injection at this level should improve the claimant's back pain.

b. Facet joint hypertrophy is identified at L2-3, L3-4, L4-5, and L5-S1. Arthritis in each one of these facets could be a source of back pain. Further studies with facet injections would be appropriate before an interbody fusion is undertaken.

c. The claimant is a 1/2 pack per day smoker. Smoking is associated with failure of bone fusion. It is recommended for the claimant to quit smoking prior to a fusion procedure. The record does not indicate a plan for smoking cessation.

ODG:

Laminectomy/ laminotomy Recommended for lumbar spinal stenosis. For patients with lumbar spinal stenosis, surgery (standard posterior decompressive laminectomy alone, without discectomy) offered a significant advantage over nonsurgical treatment in terms of pain relief and functional improvement that was maintained at 2 years of follow-up, according to a new SPORT study. Discectomy should be reserved for those conditions of disc herniation causing radiculopahy. Laminectomy may be used for spinal stenosis secondary to degenerative processes exhibiting ligamental hypertrophy, facet hypertrophy, and disc protrusion, in addition to anatomical derangements of the spinal column such as tumor, trauma, etc. (Weinstein, 2008) (Katz, 2008) This study showed that surgery for spinal stenosis and for disc herniation were not as successful as total hip replacement but were comparable to total knee replacement in their success. Pain was reduced to within 60% of normal levels, function improved to 65% normal, and quality of life was improved by about 50%. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. (Hansson, 2008) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) In patients with spinal stenosis, those treated surgically with standard posterior decompressive laminectomy showed significantly greater improvement in pain, function, satisfaction, and self-rated progress over 4 years compared to patients treated nonoperatively, and the results in both groups were stable between 2 and 4 years. (Weinstein, 2010) Laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The lamina of the vertebra is removed or trimmed to widen the spinal canal and create more space for the spinal nerves. See also Discectomy/laminectomy for surgical indications, with the exception of confirming the presence of radiculopathy. 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)