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# Notice of Independent Review Decision

## IRO REVIEWER REPORT – WC (Non-Network)

**DATE OF REVIEW:** 09/06/11

**IRO CASE #:**

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

Inpatient two day length of stay redo lumbar decompression at L3-L4 and preoperative laboratory work

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

Board Certified in Orthopedic Surgery

**REVIEW OUTCOME**

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

**X** 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.

Inpatient two day length of stay redo lumbar decompression at L3-L4 and preoperative laboratory work - Upheld

The Official Disability Guidelines (ODG) for the Low Back - Lumbar & Thoracic used were provided by the carrier/URA

**PATIENT CLINICAL HISTORY**

An MRI from 12/10/09 revealed status post L4 and L5 laminectomies and grade 2 anterolisthesis of L4 and L5. There was compression of both L4 and L5 nerve

roots at the L4-L5 level due to anterolisthesis and broad based disc herniation. At L5-S1, there was a right paracentral disc herniation with compression of the right S1 nerve root and mild compression of both L5 nerve roots. The patient underwent a redo bilateral laminectomy at L4-L5 and L5-S1 with medial one-third facetectomy, Fortis bone instrumentation at L4-L5, and Silverton pedicle screw instrumentation at L4-L5 on 03/03/10 with Dr. On 12/09/10, Dr. recommended ESIs and aquatic therapy, as the EMG/NCV study was denied. Dr. evaluated the patient on 04/01/11. The assessments were post laminectomy syndrome in the lumbar region and myofascial pain syndrome. A lumbar ESI was recommended with fluoroscopic guidance. On 05/02/11, Dr. again recommended the lumbar ESI at L3 and L4. On 05/17/11, Dr. noted the patient had hit a road block regarding the ESIs and he noted if the ESIs were not approved, he would eventually require a redo decompression at L5-S1 and L3- L4. Dr. recommended a bilateral redo decompression with foraminotomies at L5- S1, a bilateral decompression with posterior interbody fusion, posterolateral fusion, and pedicle screw instrumentation at L3-L4 on 06/28/11. On 07/12/11, Dr. provided a non-authorization from for the proposed surgery per the ODG. Dr. also provided a non-authorization from from the proposed surgery according to the ODG.

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

After review of the records, I am in agreement with the previous adverse determinations. The ODG criteria for fusion have not been met and will be discussed below. For chronic low back problems, fusion should not be considered within the first six months of symptoms, except for fracture, dislocation or progressive neurological loss and this criteria has not been met.

Indications for spinal fusion may include:

(1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. This has not been met.

(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) This criteria has not been met.

(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 rehabilitation preoperatively, total disability over six months, active psychiatric diagnosis, and narcotic dependence. This

patient has long term narcotic dependence. Spinal instability criteria includes lumbar inter- segmental movement of more than 4.5 mm. (Anderson, 2000) This criteria has also not been met.

(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. It should be noted this is the third attempted surgery for the patient.

(5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit, and/or functional disability. This criteria has not been met.

(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. This has not been met.

The following preoperative surgical indications are recommended by the ODG:

Preoperative clinical surgical indications for spinal fusion should include all of the following:

(1) All pain generators are identified and treated. This has not been met.

(2) All physical medicine and manual therapy interventions are completed. This has not been documented in the records provided.

(3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology. It does not appear that the patient's symptoms necessarily correlate with the imaging.

(4) Spine pathology limited to two levels, which has not been met.

(5) Psychosocial screen with confounding issues addressed and this has not been met.

(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. It is not known at this time if the patient is a smoker.

Therefore, for the reasons listed above, the requested inpatient two day length of stay redo lumbar decompression at L3-L4 and preoperative laboratory work is neither reasonable nor necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE

☐ 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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

X 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)