

AccuReview
An Independent Review Organization
(903) 749-4271 (phone)
(800) 764-0231 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 6, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

63042 - Laminotomy, Single Lumbar
22558 - Lumbar Spine Fusion
22585 - Additional Spinal Fusion
22612 – Lumbar Spine Fusion
22614 – Spine Fusion, Extra Segment
22842 – Insert Spine Fixation Device
22845 – Insert Spine Fixation Device
20931 – SP Bone Algrft Struct Add-On

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

This physician is Board Certified Neurological Surgeon with over 40 years of experience.

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

August 26, 2008: Operative Report by Dr. Preoperative diagnosis: Herniated cervical disc, C6-7. Procedure: C6-7 anterior cervical discectomy and fusion with allograft bone spacer and titanium plate with screws. Right iliac crest bone

marrow aspirate for the purpose of fusion, separate incision. Postoperative diagnosis: Herniated cervical disc, C6-7

December 1, 2008: CT Cervical Spine revealed post-operative changes at C6-7 with no evidence of hardware failure or loosening. No fracture or malalignment is identified. Old healed granulomatous disease is noted incidentally within the chest. Diag/Pelvis view revealed no evidence of fracture or acute traumatic injury. Diag/Cervical Spine revealed postoperative findings of previous discectomy with anterior screw plate fixation is noted at the C6-7 level as before. No significant change or adverse feature is noted. No fracture or acute traumatic injury is identified. Diag/ left Shoulder revealed no evidence of acute traumatic injury. Slight flattening to the superior posterior humeral head could indicate previous shoulder dislocation and correlation with the patient's clinical history is necessary.

MRI Thoracic Spine revealed small paracentral disc protrusions are present at multiple levels. Small one is present on the left at T6-7, on the right at T7-8 and centrally at T8-9, and left paracentral regions T9-10. These produce only mild effacement to the thecal sac. No spinal stenosis. No compression fractures.

MRI Lumbar spine revealed small central disc protrusions at L3-4 through L5-S1. No spinal stenosis, but the patient does have bilateral lateral recess stenosis. No compression fractures.

December 17, 2008: Ms. was examined by Dr. who sent her for physical therapy.

January 7, 2009: Ms. was examined by Dr. who ordered an EMG and nerve conduction study of her legs to rule out the possibility of neuropathy and try some steroid injections for her congenital stenosis.

January 8, 2010: Report of Medical evaluation by Dr. who certified that Ms. had not reached MMI but was expected to do so on 6/8/10.

January 12, 2011: report of Medical Evaluation by Dr. MD who certified that Ms. had not reached MMI but was expected to do so on 4/12/2011.

January 17, 2011: Ms. was evaluated by Dr. MD who diagnosed her with a history of right-sided radiculopathy and discectomy, recurrent right leg radiculopathy, lumbago and lumbar spondylosis L3-4, L4-5 and L5-S1. He recommended an MRI of the l-spine to evaluate for recurrent disc herniation or other areas of stenosis.

April 11, 2011: A DWC form 73 was completed by Dr. MD allowing Ms. to return to work as of 1/18/11 without restrictions for her left shoulder. Report of Medical Evaluation by Dr. MD who certified that Ms. had reached clinical MMI as of 1/18/11 with an impairment of 11% on her shoulder.

April 12, 2011: MRI of the Lumbar spine revealed developmentally small spinal canal, L3-4 through L5-S1. Posterior disc bulges, L3-4 through L5-S1. Mild to moderate central spinal canal stenosis, L3-4 and L4-5. Extensive marrow edema and enhancement in the bodies of L4 and L5 related to the disc degenerative process.

April 18, 2011: Ms. was evaluated by Dr. MD who recommended an anterior interbody and posterior fusion from L3-S1 along with a revision and decompression at L4-5. He prescribed her Flexeril for muscle spasms.

April 25, 2011: Ms. was evaluated by Dr. MD who requested a psychiatric evaluation and discussed trying another course of therapy.

May 2, 2011: Psychological Diagnostic Interview and Testing by Ed.D., who noted a diagnostic impression of pain disorder associated with psychological factors and general medical condition, chronic pain from injury, chronic pain, significant disruption of activities of daily living, inability to work, financial stress in that she is using up resources and having to get help from friends. He recommended that there are no psychological issues that would prevent her from being a candidate for surgery.

July 18, 2011: Ms. was examined by Dr. who noted that she had lumbosacral spondylosis, lumbago and lumbosacral radiculopathy. He recommended a surgical intervention (anterior interbody and posterior fusion from L3-S1 along with a revision and decompression at L4-5 and discectomy let L5-S1).

July 21, 2011: M.D. performed an UR on the claimant.

August 8, 2011: M.D performed an UR on the claimant.

August 9, 2011: Ms. was evaluated by Dr. MD who noted that Ms. had no symptoms and was unrestricted in her activities until the accident occurred. She felt that she would not likely reach MMI at any time in her life without surgery for the stenosis of the central canal and exit foramina. She felt that she has intractable anatomic changes that are not treatable with exercise and that she is most likely to get relief from a surgical correction for her stenotic area.

PATIENT CLINICAL HISTORY:

The claimant is a female with a history of lumbar injury in xxxx.

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

The previous decisions are upheld. Based on the medical records provided for review, the claimant's condition appears to have plateaued. The claimant should seek further conservative care before surgical intervention. Furthermore there is no documentation that the claimant has stopped smoking for 6 weeks which is indicated per the ODG before spinal fusions.

PER THE ODG:

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 - Spondylytic 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](#))

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)