

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** August 7, 2012

**IRO CASE #:**

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

L3-S1 Posterior Lumbar Interbody Fusion with 2 Days Inpatient Hospital Stay

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

This physician is Board Certified by the American Board of Neurological Surgery with over 16 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

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

02/22/02: MRI Report of the Lumbar Spine with and without Contrast interpreted  
12/09/03: Operative Report  
07/21/06: Office Visit by  
09/15/11: MRI Report of the Lumbar Spine with and without Contrast  
11/01/11: Initial Neurological Evaluation  
12/06/11: EMG Report  
12/14/11: Neurological Followup  
12/28/11: Neurological Followup  
02/24/12: Operative Note  
03/12/12: Pain Institute Initial Evaluation  
04/23/12: Neurological Followup  
05/22/12: Evaluation

06/13/12: UR performed

06/26/12: UR performed

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who injured her back while picking up a heavy box at work. She is status post left hemilaminectomy at L5-S1 with discectomy and bilateral hemilaminectomy at L4-L5 with discectomy.

02/22/02: MRI Report of the Lumbar Spine with and without Contrast.

Conclusion: No evidence for recurrent disc herniation. Facet degenerative change L4-L5 and L5-S1. Neural foraminal stenosis to a high degree at L5-S1 on the left as detailed above.

12/09/03: Operative Report Preoperative Diagnosis: Post lumbar laminectomy syndrome. Lumbar spondylosis with radiculopathy. Proposed Procedure: Epidural steroid injection.

07/21/06: The claimant was evaluated MD who diagnosed her with plantar fasciitis and stated that her back condition was stable.

09/15/11: MRI Report of the Lumbar Spine with and without Impression: Narrowing of the neural foramina at L4-L5 and L5-S1, worse on the left. Moderate to severe canal stenosis at L3-L4 due to severe ligamentum flavum hypertrophy. Moderate canal stenosis at L2-L3 again due to ligamentum flavum hypertrophy. There is interval progression of canal stenosis and neural foraminal stenosis compared to previous.

11/01/11: The claimant was evaluated MD who noted that she was having lower back pain with right leg pain and right hip pain. She complained of numbness in the thigh and lateral back area down to the foot and lateral toes. It was noted that she had three surgeries. She had not had any physical therapy. Medications included Neurontin and Percocet. On examination, she had a limp on the right side when walking. There was little muscle spasm to the right side into the SI joint region and sciatic notch. She had increased sensation in an S1 and L5 pattern on the right. The plan was to obtain an EMG nerve conduction study.

12/06/11: EMG Report. IMPRESSION: The above electrodiagnostic study reveals evidence of moderate-severe chronic S1 radiculopathy on the right, evidence of diffuse sensory motor peripheral neuropathy of bilateral lower extremities, and no evidence of acute lumbar radiculopathy in the L1-S1 distribution bilaterally.

12/14/11: The claimant was seen MD who noted that she would submit her old records to see what condition of all of her lumbar discs were like at the time of her accident/injury. He was to see her back with the records in 1-2 weeks.

12/28/11: The claimant was evaluated MD who noted that she was still having problems with pain, particularly right-sided. It was noted that her MRI was showing L2-L3 and L3-L4 moderate to severe spinal stenosis and some S1 foraminal findings. He recommended that she see Dr. and then followup in 2-3 weeks.

02/24/12: Operative Note by Postoperative Diagnosis: Spinal canal stenosis. Lumbago. Procedure: Caudal epidural steroid injection.

03/12/12: The claimant was evaluated MD who noted that she reported back pain but mainly sciatica pain. She reported that Percocet and ibuprofen made the pain better and that PT completed 20 years ago helped some. It was noted that she had several injections, the most recent helping somewhat but not enough to her liking. She reported having tried a TENS unit and PT that helped for about 1-2 weeks in the past. She had not tried biofeedback or psychology for the pain. It was noted that her MRI of the lumbar spine done on 02/21/12 showed no evidence of recurrent disc herniation. Facet degeneration was noted at L4-L5 and L5-S1. Neural foraminal stenosis of high grade degree was at L5-S1 on the left. Her current medications included Percocet, ibuprofen, and Neurontin. On physical exam, strength in the lower extremities was equal bilaterally, 5/3. She had normal tone and muscle bulk without obvious atrophy. She had full range of motion in the back with straight leg negative bilaterally. Patrick's was positive on the right and tender to palpation over the right sacroiliac joint. Her gait appeared to be normal. Her DTRs were equal and symmetric with patellar being 2+ bilaterally and Achilles being 0+ bilaterally. Dr. stated that a right transforaminal epidural injection at L5-S1 may benefit her. He felt that she had a component of right sacroiliac joint pain or right sacroiliitis. He told her that that this would be a potential target for injection should the right transforaminal steroid injection not assist in her overall pain state.

04/23/12: The claimant was seen by MD who noted that she was having back and right leg pain. She stated that the epidural injection performed on 04/24/12 helped her for about 1- 1 ½ weeks. It was noted that she was denied more injections. It was noted that she had therapy and that she had nerve studies showing L1 to S1 radiculopathy. MRI showed multilevel lumbar stenosis. It was noted that she had been off work. She was referred for surgical consult.

05/22/12: The claimant was evaluated MD, who noted that she complained of chronic low back pain with radiculopathy in the right leg with paresthesias in the right ankle and foot. She noted that over the past year, she had been experiencing severe shooting pain from the right buttock down the leg. She stated that this was different from her "normal" pain. It was noted that she had been undergoing chronic pain management with Dr reviewed her recent MRI demonstrating extensive postsurgical changes of decompression, L4 to S1, with significant underlying congenital stenosis as well as significant lateral recess stenosis. The L3-L4 level appeared pretty stenotic now as well. On physical

exam, she had some motor weakness in the right quadriceps. The patellar tendon reflex was not diminished. She had an absent right ankle jerk, 1+ to 2+ on the left. There was focal tenderness in the back just to the right of midline. Her gait was antalgic. SUMMARY: It appears that she has significant stenosis at L3-L4. This may be causing the more proximal weakness in her leg. The other symptoms appear to be more in the L5-S1 distribution. In any case, there is underlying congenital stenosis up and down her spine. The worst areas were definitely from L3 down to the sacrum. I do not think a simple decompression would help her at this point. Because of the extensive scar tissue and osteophytes, we will likely have to remove the entire inferior facet complexes from L3 down to L5 and significant undercut the superior facets to decompress the lateral recess and foramina. This would necessarily destabilize her spine. She will need pedicle-screw and interbody fixation at the same time. Again, I do not think a simple decompression will help her. We will submit the request to her worker comp insurance and get her on the schedule as soon as it is approved. We will continue to follow her closely.

06/13/12: UR performed. I discussed this case with Dr. He states the claimant has significant stenosis with quad weakness. However, there is no instability present. This request does not meet guideline criteria for instability to warrant fusion. Guidelines indicate all pain generators must have been identified and treated and all physical medicine and manual therapy interventions must have been completed. X-rays must demonstrate spinal instability of CT myelogram, discogram, or MRI must demonstrate disc pathology correlating to the symptoms and examination findings. Spinal pathology must be limited to two levels and a psychological evaluation with confounding issues addressed must be documented. Records do not reflect a psychological evaluation has been performed. There are no x-ray or MRI studies documenting spinal instability at the requested surgical levels. There is no documentation that all physical medicine and manual therapeutic interventions have been exhausted such as a home exerciser program, physical therapy, chiropractic care, or epidural steroid injections.

06/26/12: UR performed. This patient has already had three spine surgeries and has noted stenosis at L3-L4 but also at L2-L3. The proposed surgery at L3-L4 to L5-S1 will create a lever arm that will create significant stresses at the adjacent levels. The L2-L3 level is not normal. Thus, the proposed surgical intervention is unlikely to provide any long term benefit and alternative treatments should be considered. Moreover, the ODG does not support the use of multiple level fusions. On 06/26/12 at 9:45 am, I spoke with Dr. We discussed the patient's clinical course. He agreed that L2-L3 was not normal. A RME would be prudent before any spine surgery is completed.

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

The previous adverse decisions are upheld. The claimant has chronic right S1 radiculopathy by EMG performed on 12/06/11 as well as sensory motor peripheral neuropathy and no acute radicular findings. Her chronic back complaints preventing her return to work since 1995 do not have any clear role for fusion defined. There are no lumbar x-rays or CT scans showing instability, neural arch defects or deformity. The Lumbar MRIs do not show recurrent disc herniations warranting a repeat discectomy that would require a fusion possibly. Her main findings on the MRIs are at L2-L3, L3-L4 and on the left at L5-S1. She also has not had a psychosocial screen which may point up other concerns contributing to chronic back pain, prior to further interventions. The claimant may benefit from decompressive laminotomy at L2-L3 and L3-L4 or lumbar spinal cord stimulator trial. She is not a candidate for a lumbar instrumented fusion based on her history or radiographic findings. Therefore, the request for L3-S1 Posterior Lumbar Interbody Fusion with 2 Days Inpatient Hospital Stay is not medically necessary and is non-certified.

ODG:

Fusion (spinal)	<p><b>Patient Selection Criteria for Lumbar Spinal Fusion:</b>  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. (<a href="#">Andersson, 2000</a>) (<a href="#">Luers, 2007</a>) (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. (<a href="#">Andersson, 2000</a>) (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 <a href="#">ODG Indications for Surgery -- Discectomy.</a>)</p> <p><b>Pre-Operative Surgical Indications Recommended:</b> Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; &amp; (2) All physical medicine and manual therapy interventions are completed; &amp; (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see <a href="#">discography criteria</a>) &amp; MRI demonstrating disc pathology correlated with symptoms and exam findings; &amp; (4) Spine pathology limited to two levels; &amp; (5) <a href="#">Psychosocial screen</a> 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</p>
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	<p>prior to surgery and during the period of fusion healing. (<a href="#">Colorado, 2001</a>) (<a href="#">BlueCross BlueShield, 2002</a>)</p> <p>For average hospital LOS after criteria are met, see <a href="#">Hospital length of stay</a> (LOS).</p>
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Hospital length of stay (LOS)	<p><b>ODG hospital length of stay (LOS) guidelines:</b></p> <p><b>Lumbar Fusion, posterior</b> (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>)</p> <p>Actual data -- median 3 days; mean 3.9 days (<math>\pm 0.1</math>); discharges 161,761; charges (mean) \$86,900</p> <p>Best practice target (no complications) -- 3 days</p>
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**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)**