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Notice of Independent Review Decision

DATE OF REVIEW: 2/17/12

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: L5-S1 laminectomy, discectomy, fusion with instrumentation with 2 day LOS CPTA: 63030, 63035, 22612, 22851, 20938, 22840, 22558, 22325

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

Denial Upheld

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

Clinical notes dated 05/20/2011, 10/07/2011, 09/20/2011, and 11/01/2011, 08/05/2011, 07/22/2011, 07/14/2011, 06/23/2011, 06/09/2011, 06/03/2011, and neurodiagnostic test dated 08/29/2011, MRI of the thoracic spine dated 05/20/2011, and MRI of the lumbar spine 05/20/2011, health surgical clearance screening with MMPI dated 10/18/2011 and 12/13/2011, MRI scan review dated 05/20/2011, and manuscript procedure note dated 09/12/2011, and review determinations dated 01/12/2012 and 01/20/2012, lumbar spine x-ray report dated 01/16/2012.

PATIENT CLINICAL HISTORY (SUMMARY):

This is a male with low back pain. On xx/xx/xx, this patient had MRI of the lumbar spine. There was multi-level disc desiccations with height loss noted, Schmorl's nodes and type II Modic

changes seen about the lumbar spine. At L5-S1, there was a disc bulge with more prominent disc protrusion seen causing no significant central canal narrowing. There was moderate left neural foraminal narrowing secondary to facet arthropathy and disc bulge. The right neural foramina was mildly narrowed. At L3-L4 through L4-L5, a disc bulge, facet arthropathy, and ligamentum flavum hypertrophy caused no significant central canal narrowing. There was mild to bilateral neural foraminal narrowing at those levels. On 08/29/2011, this patient had electrodiagnostic studies. Bilateral sural and subperoneal sensory nerve action potentials demonstrated normal distal latencies and amplitudes. The left median plantar mixed nerve action potential demonstrated normal distal latency and amplitude. The right medial plantar mixed nerve was not clearly demonstrated. The bilateral tibial and peroneal compound motor action potentials demonstrated normal distal latencies and amplitudes. There were normal motor conduction velocities of the bilateral tibial nerves. Overall assessment was that there was no evidence of left or right lumbar radiculopathies, sacral plexopathies, or focal peroneal or tibial neuropathies in the knee or ankle segments, or limbs peripheral polyneuropathies or myopathies. On 09/01/2011, this patient was seen in clinic again. He stated that his left leg pain was progressively worse. He denied bowel or bladder incontinence. Pain was rated at 10 in the lower back area. On exam, range of motion was restricted. SI joints were negative. Straight leg raise was positive on the left side, both in the sitting and standing positions, with weakness in the left lower extremity. Sensation appeared diminished in the left L4-L5 and S1 nerve distributions with absent reflex in the left ankle area and mild weakness in the left extensor hallucis longus. On 09/12/2011, this patient was taken to surgery for left L5-S1 transforaminal epidural steroid injections. On 11/01/2011, this patient was seen in clinic. Chief complaint was back pain with radiation to the left leg and numbness and tingling. On exam, he denied bowel or bladder incontinence. X-rays of his lumbar spine revealed functional spinal unit, collapse at L5-S1 only with standing lateral views. In addition, there was posterior column deficit, facet subluxation, foraminal stenosis, and lateral recess stenosis. On physical examination, he had muscle spasms and a positive sprain test at L5-S1, and a positive sciatic notch tenderness on the left only. He had a positive extensor lag and negative Fortin Finger test. He had a positive Flip test on the left and positive Lasegue's test on the left. He had absent posterior tibial tendon jerks bilaterally and hypoactive ankle jerk on the left and paresthesias in the L5-S1 nerve root distribution on the left. On 12/13/2011, this patient had surgical evaluation. He was deemed a good candidate for surgery at that time.

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

The initial review analysis reported on 01/12/2012 indicated that the patient had left leg pain and objective findings on the exam and MRI findings on the left at L5-S1. It was sought he would be a candidate for left L5-S1 laminectomy, but there was no indication for effusion such as instability, fracture, spondylolisthesis to warrant a fusion. As such, the request was considered non-certified. The subsequent appeal analysis reported on 01/20/2012 indicated that fusion would be recommended in the presence of spinal instability, either on flexion or extension used or following a decompressive procedure that creates instability. It was noted that the L5-S1 level did not satisfy guidelines for instability and given that the proposed surgery would not actually address the 2 levels that do satisfy the guidelines for instability, and given the spine pathology is not limited to levels, guidelines were not satisfied, and the proposed surgical intervention was considered non-certified. In analyzing the first report, the review indicated that there was no documentation of instability or spondylolisthesis. The medical records submitted for this review support that, and there is no documentation of instability or spondylolisthesis in the submitted documents. The second review indicates that this was effusion where there were multiple levels of degenerative disc disease and there was no indication for effusion at L5-S1, as there was no documented instability or spondylolisthesis. It was further noted that the proposed procedure at

L5-S1 laminectomy and fusion would not address additional levels of degenerative disease. Medical records submitted for this review uphold those thoughts, as there is no documentation

of instability at L5-S1 level and no documentation of significant spondylolisthesis. In addition, there is recommendation of at least 3 levels that have degenerative disc disease for L4-L5 and L5-S1. As such, the requested procedure is not considered reasonable and necessary, and the original decision and appeal decisions are upheld.

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

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
Low Back Chapter, Online Version.
- 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)

REFERENCES: Official Disability Guidelines, Low Back Chapter, Online Version.

REFERENCES: Official Disability Guidelines, Low Back Chapter, Online Version.
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.)

Patient Selection Criteria for Lumbar Spinal Fusion:

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.

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

- C. L5 nerve root compression, requiring ONE of the following:
 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 3. Unilateral hip/lateral thigh/knee pain

- D. S1 nerve root compression, requiring ONE of the following:
 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 3. Unilateral buttock/posterior thigh/calf pain

([EMGs](#) are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

1. [MR](#) imaging
2. [CT](#) scanning
3. [Myelography](#)
4. [CT myelography](#) & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. [Activity modification](#) (not bed rest) after [patient education](#) (≥ 2 months)
- B. Drug therapy, requiring at least ONE of the following:
 1. [NSAID](#) drug therapy
 2. Other analgesic therapy
 3. [Muscle relaxants](#)
 4. [Epidural Steroid Injection](#) (ESI)
- C. Support provider referral, requiring at least ONE of the following (in order of priority):
 1. [Physical therapy](#) (teach home exercise/stretching)
 2. [Manual therapy](#) (chiropractor or massage therapist)
 3. [Psychological screening](#) that could affect surgical outcome
 4. [Back school](#)