

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** July 16, 2012

**IRO CASE #:**

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

Inpatient Anterior Lumbar Interbody Fusion L5-S1/Bone Marrow Aspiration

### **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 Orthopaedic Surgery 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)

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:**

01/22/10: Notice of Disputed Issue(s) and Refusal to Pay Benefits from Division of Workers' Compensation

06/14/10: Operative Report by DO with LTD

07/26/10: Operative Report by DO with Pine Creek Surgery Center

12/23/10: MRI L-Spine W/WO Contrast interpreted by MD with Imaging

03/21/11: Operative Report by DO with

04/25/11, 06/15/11, 07/18/11, 09/09/11, 11/09/11, 12/21/11, 04/04/12: Followup Visits by DO

04/06/12: Psych Diagnostic Interview and Testing by PsyD and EdD with Spinal Rehabilitation Center, Inc.

05/09/12: Followup Visit by DO

05/17/12: Pre-Authorization Request from DO

05/21/12: UR performed by MD

06/04/12: Letter of Reconsideration by with DO

06/13/12: UR performed by MD

06/20/12: Followup Visit by DO

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his back while working on xx/xx/xx. He is status post microscopic lumbar laminectomy, partial facetectomy, and neural foraminotomy, discectomy L5-S1 on the right on 07/02/10.

01/22/10: Notice of Disputed Issue(s) and Refusal to Pay Benefits from Division of Workers' Compensation. The claimant's compensable injury is limited to lumbar sprain/strain, as there have been no true radicular signs of symptoms during the course of this injury. No other conditions naturally resulted from or was affected by the original incident. All other injuries, conditions, diagnoses, and/or symptoms related to another part of the claimant's body are denied as not resulting from the accident. Therefore, any inability to maintain or retain employment is not related to the compensable injury.

06/14/10: Operative Report by DO. Postoperative Diagnoses: 1. Herniated nucleus pulposus, L5-S1 on the right. 2. Lumbar radiculopathy. Operations Performed: 1. Caudal epidural steroid injection. 2. Fluoroscopy.

07/26/10: Operative Report by DO. Postoperative Diagnoses: 1. Herniated nucleus pulposus, L5-S1 on the right. Operations Performed: 1. Microscopic lumbar laminectomy, partial facetectomy, and neural foraminotomy along with discectomy at L5-S1 on the right. 2. Fluoroscopy.

12/23/10: MRI L-Spine W/WO Contrast interpreted by MD. IMPRESSION: 1. There is mild to moderate disc dehydration and mild loss of disc space height at L5-S1. There are postoperative changes from a right-sided laminectomy at this level. There is prominent enhancing soft tissue surrounding the thecal sac, more evident to the right of midline and surrounding the right S1 nerve root. This should reflect granulation tissue. No residual or recurrent disc protrusion or focal mass effect on nerve roots is apparent. There is no high-grade central or foraminal stenosis. 2. Minor facet hypertrophy noted at L4-L5 and L3-L4. No focal disc protrusion at these levels. No significant central or foraminal stenosis. 3. The upper lumbar levels and conus are unremarkable. There is no abnormal enhancement involving the conus or the canal.

03/21/11: Operative Report by DO. Postoperative Diagnoses: 1. Postlaminectomy syndrome. 2. Lumbar radiculitis. Operations Performed: 1. Caudal epidural steroid injection. 2. Fluoroscopy.

04/25/11: The claimant was reevaluated by DO who noted that the epidural injection performed on 03/21/11 alleviated all of his radiating leg pain. He stated that the majority of his pain was in an area of the lumbar spine region, over the area where his incision was. He reported 3/10 pain. He was taking Ultracet and Soma. On examination, he could heel and toe walk without pain. There was tenderness to palpation over the L5-S1 area. There was mild right upper gluteal pain. He could forward flex over to 30 degrees. He could extend to 5 degrees and rotate and side bend 5-10 degrees with mild discomfort. Negative indirect straight leg raised and supine straight leg raised. Sensory was symmetrical. DTRs were +2 patellar and +1 Achilles on the left and +1 on the right. Motor testing was 5/5 hip flexion, leg extension, leg flexion, tibialis anterior, EHL, and gastroc soleus. Dr. Benbow faxed a prescription for him to complete his work

hardening program. He was continue on Ultracet and Soma. He was to remain off work as there was no light duty for him to return to.

06/15/11: The claimant was reevaluated by who noted that he had completed his functional restoration program. He was cleared to return back to work with frequent lifting of 28 pounds and occasional lifting up to 56 pounds. He stated that overall his symptoms were about the same. He rated his pain as 3/10. On examination, he had a normal heel strike, toe-off gait pattern. He could heel and toe walk without difficulty. He continued to have moderate to severe tenderness over the area of the incision and right paraspinous region. There was mild right gluteal discomfort. He could forward flex to around 30 degrees. There was negative SLR up to 75 degrees. DTRs were +2 patellar and +1 Achilles on the right and +1 on the left. Sensory was intact and symmetrical in bilateral lower extremities. There was 5/5 hip flexion, leg extension, leg flexion, tibialis anterior, EHL bilaterally with gastroc soleus testing with toe raising on the left. He had 4+/5 weakness on the right with gastroc soleus testing. PLAN: He states the lifting restrictions now are 50-100 pounds at his job, so he is not optimistic that he will be able to return back to work. His options are to proceed with retraining at DARS once he is placed at MMI and has his impairment rating. If his symptoms worsen, and his able to tolerate the pain, then fusion surgery is still an option for him at the L5-S1 level. Presently, he would like to return back to work and see if his job will accept him back. Based upon the severe tenderness in the paraspinous region, I went ahead and performed trigger point injections the three separate areas after the skin was prepped with alcohol.

07/18/11: The claimant was evaluated by DO. The claimant reported right gluteal pain without radiating pain down his leg. He had normal heel-strike, toe-off gait pattern. He could heel and toe walk without difficulty. He had moderate tenderness over the incision area. There was negative SLR bilaterally. DTRs were +2 patellar bilaterally, +1 Achilles on the right and +1 on the left. Sensory was intact and symmetrical in bilateral lower extremities. There was 5/5 hip flexion, leg extension, leg flexion, tibialis anterior, EHL, and gastroc soleus testing. He did have some persist mild weakness with toe raising on the right gastroc soleus complex at 4+/5 on the right compared to 5/5 on the left. He was given a prescription for a Lidoderm pain patch to try He was referred for an impairment rating since he had reached MMI.

09/09/11: The claimant was reevaluated by DO. His complaints remained unchanged. Physical exam remained unchanged since 07/18/11 with the following exceptions: There was no weakness with toe raising on the right gastroc soleus complex noted on this exam. PLAN: We have reviewed his impairment rating. At this point, the patient does not want to proceed with any fusion or disc replacement surgery. We will sign off on his impairment rating and would recommend him to be evaluated by Dr. for lysis of adhesions to see if this might help some of his persistent discomfort.

11/09/11: The claimant was reevaluated by DO. It was noted that there was a delay in getting the referral for lysis of adhesions processed. His complaints remained unchanged. He reported only taking Soma as needed. He was not taking Tramadol. Physical exam remained unchanged since 07/18/11 with the following exceptions: With supine straight leg raising, at about 45-50 degrees, he does have some pain in the right gluteal area. DTRs were +2 patellar bilaterally and +2 Achilles on the right and +1 on the left. PLAN: We will make another referral for him to undergo lysis of adhesions. He is pending his impairment rating, but will be at statutory MMI on 12/09/11.

12/21/11: The claimant was reevaluated by DO who noted that his impairment rating was administered at 10% impairment. He had been official terminated from his job. It was noted that he could stand for 20-30 minutes before he needed to sit down and rest. On physical exam, there was a positive supine straight leg raising at 45-50 degrees with pain in the right gluteal area. There was negative SLR on the left. DTRs were +2 patellar bilaterally, +2 Achilles on the right and +1 on the left. Sensory was intact and symmetrical in bilateral lower extremities. There was 5/5 hip flexion, leg extension, leg flexion, tibialis anterior, and EHL. There was some mild gastroc soleus weakness at 4+/5 on the right compared to 5/5 on the left. PLAN: At this point, he is willing to undergo a definitive procedure to take care of this ongoing pain from incompetent disc at L5-S1. We will send him for a psych evaluation for the possibility of fusion at L5-S1, along with AP, lateral, and flexion/extension views of the lumbar spine. We will see him back for recheck in six weeks.

04/04/12: The claimant was reevaluated by DO who noted that he reported average 7/10 pain. He stated that he was having worsening pain, more and more sitting and standing intolerance. Physical exam was unchanged when compared to 12/21/11. PLAN: We have encouraged him to get his psychological evaluation done as quickly as possible. Will see him back in 3-4 weeks. Would recommend proceeding with any surgical requests at that time for anteroposterior fusion, L5-S1.

04/06/12: Psych Diagnostic Interview and Testing by, PsyD and EdD with Spinal Rehabilitation Center, Inc. SUMMARY AND RECOMMENDATION: He meets the criteria for the diagnosis of pain disorder with psychological factors. Clinical observations and current psychological testing indicates that he is again having difficulty coping with his pain condition and has now reached a juncture at which he must decide whether to proceed with a fusion procedure, which further causes distress. He has been observed in the functional restoration setting to be well capable of managing his psychological distress, and we did discuss some of the techniques previously learned. It is my opinion that, once Mr. makes his decision, he would likely be able to employ adaptive coping strategies to situations. Given these factors, it is my impression that no psychological issues appear to be present that would prevent Mr. from undergoing a surgical procedure such as lumbar fusion should he and his surgeon wish to pursue this treatment.

05/09/12: The claimant was reevaluated by DO who noted that his pain was keeping him from sleeping. He rated it around 7-8/10. He was noted to only be using OTC medications. Physical exam remained unchanged when compared to 04/04/12 and 12/21/11. PLAN: Based upon his failure to respond to microdiscectomy as well as work hardening and work conditioning and subsequent postop injections, I have recommended that he undergo anterior lumbar interbody fusion at L5-S1 due to the incomplete disc that he has and his ongoing back and leg symptoms.

05/21/12: UR performed by MD. Claimant is status post microscopic lumbar laminectomy, partial facetectomy, and neural foraminotomy, discectomy L5-S12 on the right on 07/02/10. Most recent MD note is 05/09/12. MRI from 12/23/10 reveals no evidence of instability or spondylolisthesis that would necessitate a fusion. ODG requires evidence of instability of spondylolisthesis to support fusion. Given the lack of findings by diagnostic test consistent with this criteria, request not medically necessary. Refer to ODG section 722.1 subsection under lumbar fusion.

06/13/12: UR performed by MD. Based on review of the medical records provided, the proposed treatment consisting of inpatient Anterior Lumbar Interbody Fusion L5-S1/Bone Marrow Aspiration is not medically necessary for this diagnosis and clinical findings. The claimant sustained an injury to the low back on 12/09/09. He is status post microscopic laminectomy, discectomy on the right at L5-S1 performed on 07/26/10. The MRI of the lumbar spine on 12/23/10 revealed postoperative changes with enhancing soft tissue surrounding the thecal sac, more evident to the right of the midline and surrounding the right S1 nerve root which reflects granulation tissue. There was no residual recurrent disc protrusion or focal mass effect on the nerve roots apparent and there was no high-grade central or foraminal stenosis documented. There is no evidence of spondylolisthesis and there was no flexion/extension films provided with evidence of motion segment instability at any level of the lumbar spine. The proposed surgical procedure does not meet Official Disability Guidelines criteria and surgical intervention is not indicated as medically necessary s per the given current clinical data.

06/20/12: The claimant was reevaluated by DO who noted that he continued to report 80% low back pain and 20% right gluteal pain. Physical exam remained unchanged since 05/09/12, 04/04/12, and 12/21/11. PLAN: His second surgical request was denied based on the facet that the patient is not having any instability on flexion/extension views. The patient has failed laminectomy surgery. He is a candidate for fusion at the L5-S1 level since a revision laminectomy would create instability and cause the need for the fusion. He has standing intolerance. He has failed postoperative therapy, injections, and has had an extensive period of time since his surgery to recover. He does have an incompetent disc at L5-s1 and is a candidate from a psychological standpoint for the fusion procedure. We will go ahead and submit this to an IRO for further evaluation and have him follow up in a month for recheck.

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

The previous adverse decisions are upheld. There is no ODG indication for surgery such as instability. There is no evidence of significant radiculopathy. There is no change in his condition in the past several years. The request for Inpatient Anterior Lumbar Interbody Fusion L5-S1/Bone Marrow Aspiration 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 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>
Hospital length of stay (LOS)	<p>Recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. For prospective management of cases, median is a better choice than mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. For retrospective benchmarking of a series of cases, mean may be a better choice because of the effect of outliers on the average length of stay. Length of stay is the number of nights the patient remained in the hospital for that stay, and a patient admitted and discharged on the same day would have a length of stay of zero. The total number of days is typically measured in multiples of a 24-hour day that a patient occupies a hospital</p>

	<p>bed, so a 23-hour admission would have a length of stay of zero. (<a href="#">HCUP, 2011</a>)</p> <p><b>ODG hospital length of stay (LOS) guidelines:</b></p> <p><b>Discectomy</b> (<i>icd 80.51 - Excision of intervertebral disc</i>)  Actual data -- median 1 day; mean 2.1 days (<math>\pm 0.0</math>); discharges 109,057; charges (mean) \$26,219  Best practice target (no complications) -- 1 day</p> <p><b>Laminectomy</b> (<i>icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root</i>)  Actual data -- median 2 days; mean 3.5 days (<math>\pm 0.1</math>); discharges 100,600; charges (mean) \$34,978  Best practice target (no complications) -- 1 day</p> <p><b>Lumbar Fusion, posterior</b> (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>)  Actual data -- median 3 days; mean 3.9 days (<math>\pm 0.1</math>); discharges 161,761; charges (mean) \$86,900  Best practice target (no complications) -- 3 days</p> <p><b>Lumbar Fusion, anterior</b> (<i>icd 81.06 - Lumbar and lumbosacral fusion, anterior technique</i>)  Actual data -- median 3 days; mean 4.2 days (<math>\pm 0.2</math>); discharges 33,521; charges (mean) \$110,156  Best practice target (no complications) -- 3 days</p> <p><b>Lumbar Fusion, lateral</b> (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>)  Actual data -- median 3 days; mean 3.8 days (<math>\pm 0.2</math>); discharges 15,125; charges (mean) \$89,088  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
- AHCP- 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)