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**Notice of Independent Review Decision**

**DATE NOTICE SENT TO ALL PARTIES:** 7/16/12

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 63047 Removal of spinal lamina, 22630 lumbar spine fusion, 22851, apply spine prosth device, 22842 insert spine fixation device and 2 non-emergency inpatient days.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of 63047 Removal of spinal lamina, 22630 lumbar spine fusion, 22851, apply spine prosth device, 22842 insert spine fixation device and 2 non-emergency inpatient days.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: The patient,. These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 7/5/12 letter from, various DWC 73 forms, office notes dated 2/7/11 to 3/9/12, 2/7/11 patient referral from, 2/14/11 lumbar radiographic report, 2/17/11 initial eval from PT, 2/23/11 approval letter, 3/1/11 lumbar MRI report, 3/3/11 daily notes from PT, 3/23/11 neurological exam and report by MD, 4/5/11 to 10/12/11 notes by Dr., 4/5/11 peer review report, 4/6/11 approval letter, 4/7/11 letter by DD exam dated 5/31/11 by MD, 6/20/11 approval letter, 8/30/11 approval letter, 12/15/11 to 2/9/12

notes by MD, 12/23/11 approval letter, 1/4/12 lumbar MRI report, 1/10/12 neurodiagnostic report, 1/20/12 PT script, 1/27/12 approval letter, 1/30/12 to 3/7/12 peer reviews from Physicians Ltd., 1/31/12 denial letter, 2/28/12 peer review by, MD, and 3/8/12 denial letter.

Dr.: 12/15/11 to 3/8/12 office notes by Dr..

The patient: 7/10/12 email from patient.

A copy of the ODG was not provided by the Carrier or URA for this review.

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

The claimant was injured at the low back level 2/7/11. "I squatted down...my back went out." Physical therapy records from early 2011 were reviewed. A xx/xx dated lumbar MRI revealed bilateral spondylolysis, an annular tear and nerve root impingement with disc protrusion at L5-S1. An 11/4/11 dated note revealed a normal neurologic examination. A subsequent 1/5/12 dated MRI has revealed spondylosis, scar tissue, evidence of a prior laminotomy, degenerative changes, and disc protrusion with nerve root impingement at L5-S1. L4-S1 radiculopathy was noted on electrical studies from 1/16/12. On 1/18/12, continued symptoms and now episodic falling was noted. On 2/9/12, flexion-extension x-rays were noted to not reveal subluxation. On 3/8/12, there was ongoing low back pain with left-sided sciatica, Exam findings revealed hypoactive DTRs with decreased sensation in the L5-S1 distribution, along with bilaterally positive straight leg raises. Treatment has included multiple epidural steroid injections, medications, PT and reduced activities. Nerve root blocks were noted to have temporarily resolved the patient's pain, as per the AP records dated 10/12/11. Denial letters referenced the lack of a psychosocial screen and documentation of a trial and failure of a recent comprehensive non-operative treatment program.

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

The AP's patient has had increased pain, sciatica and repetitive falls. This has all been associated with examination abnormalities, radiographic and electrical findings associated with the nerve impingement and disc/bony and nerve abnormality at L5-S1. Bilateral spondylolysis and evidence of a prior laminotomy have been documented. With a failure of prior medications, PT, injections and restricted activities, and, with corroborative nerve root blocks; decompression and fusion with instrumentation and 2 overnights are reasonable and medically necessary. Destabilization is highly probable with decompression alone. This is due to the ongoing spondylolysis and the prior diskectomy/laminectomy with additional decompression. Therefore, the entirety of the requested is appropriate. There has been adequate documentation of non-operative treatments and a psychosocial screen is unnecessary. This psychosocial screen is recommended but is not part of the selection criteria for the requested procedure. Secondly, with no psych diagnosis it is unnecessary. This patient has not had evidence of psychopathology and there exists a markedly pathological spine that warrants the requested procedures and overnights, as per applicable guideline intent and overall criteria.

Reference: ODG Lumbar Spine

### 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.)

### **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 KNOWLEDGBASE
- 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)