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Notice of Independent Review Decision

DATE OF REVIEW: 03/13/12

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:

CPT:	Description	Request Date:	Determ Date:	Status:
20938	Spine Bone Autograft	02/21/12	02/28/12	Non-Authorized
22612	Posterior Lumbar Fusion	02/21/12	02/28/12	Non-Authorized
22840	POST INSTRUM:WO SEGMT FIXA	02/21/12	02/28/12	Non-Authorized
22851	Application of Prosthetic Device	02/21/12	02/28/12	Non-Authorized
63030	Laminotomy w Decompression Nerve Root an	02/21/12	02/28/12	Non-Authorized
63035	Lumbar add'l interspace	02/12/12	02/28/12	Non-Authorized
22325	OPTX&/RDCTJ VRT FX&/ DISLC PST 1 VR	02/21/12	02/28/12	Non-Authorized
22533	LAT LUMBAR SPINE FUSION	02/21/12	02/28/12	Non-Authorized

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

Board Certified in Orthopaedic Surgery

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

This includes adverse determination letter dated 02/17/2012 and adverse determination letter dated 02/28/2012, presurgical consultation and behavioral assessment dated 02/06/2012, clinical notes dated 01/10/2012, 01/09/2012, 09/16/2011, 08/22/2011, and 08/08/2011, MRI scan review dated 01/11/2011, functional capacity evaluation dated 08/03/2011, pain management procedure note dated 06/17/2011 and 05/12/2011, electrodiagnostic studies dated 03/07/2011, MRI of the lumbar spine dated 01/14/2011, designated doctor evaluation dated 01/04/2012, peer

review performed on 01/23/2012, post designated doctor required medical examination dated 09/20/2011, peer review performed on 08/29/2011.

PATIENT CLINICAL HISTORY (SUMMARY):

This is a male with a reported date of injury of xx/xx/xx.

On 08/08/2011, this patient was seen for physical therapy.

He was returned on 09/16/2011 for evaluation. He had low back pain rated at 5/10 to 7/10.

On 01/14/2011, this patient had MRI of the lumbar spine. There was a central disc herniation at L5-S1 with mild impingement of the L5 and S1 nerve roots bilaterally. There was a disc bulge at L4-5 without impingement.

On 03/07/2011, this patient underwent electrodiagnostic studies. There was evidence of lumbar radiculopathy affecting the right L5 nerve root based on this exam. There was also evidence suggestive of bilateral S1 radiculopathy.

On 05/12/2011 and 06/17/2011, this patient was taken to surgery for low back pain with right lower extremity radicular symptoms, and procedure performed was lumbar epidural steroid injection.

On 08/03/2011, this patient underwent comprehensive functional capacity evaluation. This demonstrated he was not meeting all of his job requirements. Based on the exam, he was at light medium PDL and his work requiring medium PDL.

On 01/10/2012, this patient was seen for orthopedic surgical consult. Chief complaint was back pain and bilateral leg pain, worse on the right. On exam, he had positive spring test, inter-iliac crest line, positive extensor lag, and positive sciatic notch tenderness bilaterally. This was worse on the right. He had a positive flip test bilaterally and a positive Lasègue's on the right at 45 to 50 degrees and a positive Braggard's on the right. He had absent posterior tibial tendon jerks bilaterally and hypoactive ankle jerk on the right. Paresthesias were noted in the L5 and S1 nerve root distribution on the right and weakness of the gastrocsoleus was noted on the right. Assessment was traumatic HNP with clinical instability and failure of conservative care.

On 02/06/2012, this patient underwent presurgical consultation and behavioral assessment. He was found to be psychologically stable to undergo and benefit from the recommended surgical intervention.

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

Initial review dated 02/17/2012 indicated that the claimant did not meet criteria for lumbar fusion. There was no evidence of instability on flexion or extension x-rays. Raw data from the EMG did not support evidence of radiculopathy. This was interpreted by chiropractic, and this was not recommended by ODG. Flexion and extension x-rays

were requested for independent reading by a board certified medically trained radiologist. Clinical examinations indicated no evidence of radiculopathy by the chiropractor. Physical examination became positive for radiculopathy post lumbar MRI. Phone call after that determined that x-rays were done, but not interpreted by a radiologist. Subsequent reconsideration dated 02/28/2012 indicated that the patient had no instability that would warrant a decompression and fusion surgery. Furthermore, the MRI only showed a L4-5 disc bulge and a L5-S1 central disc with possible impingement toward the L5 and S1 nerve roots bilaterally. Additionally, it was noted he had been placed at MMI with a 5% impairment, as that examiner found no neurological deficits in the lower extremities. He had a MRI of the lumbar spine dated 01/14/2011. There is a central disc herniation at L5-S1 with mild impingement of the L5 and S1 nerve roots bilaterally, and there was a disc bulge at L4-5 without impingement. There is no indication on that exam of spondylolisthesis. Flexion and extension films were not provided for this review to demonstrate instability of the lumbar spine. Designated doctor examination on 01/04/2012 was reviewed, and muscle strength in the lower extremities was all rated at 5+/5+. The patient was able to perform the heel and toe walk without difficulties. Sensation was within normal limits. Deep tendon reflexes were 2 at the left patella and Achilles and 1 at the right patella and Achilles. As such, there is lack of significant radiculopathy and lack of documentation of instability or spondylolisthesis as recommended by ***Official Disability Guidelines.*** Therefore, the initial review is upheld and the reconsideration is upheld.

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

References:

Official Disability Guidelines, Low Back Chapter, Online Edition

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.