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Notice of Independent Review Decision

Date notice sent to all parties: 10/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminotomy (Hemilaminectomy), with decompression of nerve root(s), including partial Facetectomy, Foraminotomy, and/or Excision of Herniated Intervertebral Disc;
1 Interspace Lumbar

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

Board Certified Neurosurgeon

REVIEW OUTCOME:

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

x 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:

Clinical notes dated 04/07/05 – 07/21/05
CT myelogram of the lumbar spine dated 08/09/05
Clinical notes dated 08/11/05 – 09/23/05
Radiographs of the lumbar spine dated 09/23/05
Operative report dated 09/23/05
Discharge summary dated 09/23/05

Clinical notes dated 11/03/05 – 01/20/06
Radiographs of the lumbar spine dated 04/14/06
Clinical notes dated 03/20/06
CT myelogram study dated 04/14/06
Clinical notes dated 05/01/06 – 06/27/06
Operative report dated 07/26/06
Discharge summary dated 07/27/06
Radiographs of the lumbar spine dated 06/27/06
Clinical note dated 07/11/06
Clinical note dated 07/11/06
Radiographs of the lumbar spine dated 07/11/06
Discharge summary dated 07/11/06
Clinical notes dated 07/27/06
Radiographs of the lumbar spine dated 07/27/06
Radiographs of the lumbar spine dated 10/02/06
Clinical note dated 10/02/06
Radiographs of the lumbar spine dated 10/02/06
Clinical notes dated 12/21/06 – 06/20/07
Procedure note dated 07/20/07
Clinical notes dated 01/28/08 – 10/15/08
CT myelogram of the lumbar spine dated 12/16/08
Clinical notes dated 12/22/08 – 01/11/10
CT of the abdomen dated 01/12/10
Discharge summary dated 01/13/10
Radiographs lumbar spine dated 02/18/10
Clinical notes dated 02/18/10 – 10/28/10
Clinical note dated 03/09/12
Clinical note dated 07/19/12
CT myelogram of the lumbar spine dated 08/07/12
Clinical note dated 08/27/12
Prior reviews dated 09/11/12 and 09/19/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has been followed for chronic low back pain and has been assessed with post-laminectomy syndrome. The patient is status post L5-S1 lumbar laminectomy and discectomy completed in 09/05. The patient then underwent bilateral L5-S1 fusion in 06/06. The clinical notes indicate that the fusion at L4-5 was completed in 2010; however, no operative report was submitted for review. The clinical note from dated 03/09/12 indicated that the patient did complete a full functional restoration program. The patient was reported to have done extremely well with the program; however, the patient was not able to return to his previous job. The patient was evaluated on 07/19/12. The note indicated that the patient's low back pain had become severe and the patient ambulated with a flexed posture of the low

back. Physical examination revealed weakness of the quadriceps with decreased sensation from the mid thighs to the feet. Reflexes were absent in the lower extremities. The patient was recommended for updated CT myelogram studies which were completed on 08/07/12. Anterolisthesis was present at L3-4 with disc space narrowing at L3-4. Pseudo bulging was noted and there was moderate spinal canal and foraminal narrowing. Post myelogram CT revealed bilateral foraminal narrowing at L3-4 with maintained alignment in the lumbar spine. No spinal canal stenosis was reported. Clinical evaluation on 08/27/12 stated that the patient continued to walk with a flexed posture of the low back and had total loss of lumbar lordosis with loss of range of motion in all planes. The patient continued to demonstrate weakness in the quadriceps distally and there was decreased sensation in the mid-thighs distally. The patient required use of a cane for ambulation. The patient was recommended for a posterior L3-4 decompression and fusion and instrumentation with removal of prior L4-5 instrumentation and removal of the spinal fusion stimulator. The request for lumbar laminectomy and fusion at L3-4 with removal of a portion of the previous L4-5 instrumentation and removal of the spinal fusion stimulator battery was denied by utilization review on 09/11/12 as there was no extensive documentation regarding conservative treatment for the lumbar spine. No pre-operative psychological evaluation was provided. The request was again denied by utilization review on 09/19/12 as pain generators were not identified and there were contraindications in the CT myelogram report.

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

The request for lumbar laminectomy and fusion at L3-4 with removal of hardware at L4-5 and removal of the spinal fusion stimulator is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. Based on review of the clinical notes the patient was assessed with chronic low back pain following multiple surgical interventions including a 2-level fusion from L4-S1. The patient did not improve with surgical intervention and ultimately required tertiary levels of pain management to include a functional restoration program. At this point in time the patient has reached a tertiary level of care and it is unlikely that further surgical intervention would reasonably result in a favorable outcome. The patient did not undergo repeat psychological testing which would be indicated in this case given the patient's high level of chronic pain. Also, the CT myelogram provided for review had conflicting results as it documented evidence of spondylolisthesis and canal stenosis which was not confirmed on the post myelogram CT. Given the lack of any significant objective evidence of pathology at L3-4 that would reasonably require the requested procedures at L3-4, medical necessity would not be established.

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

**x MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**x ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**

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.](#))

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 correlated with symptoms and exam findings; & (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. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))