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Notice of Independent Review Decision

Date notice sent to all parties:

November 2, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal Lumbar Laminectomy poss Fusion L4-L5 LOS x2 days 63047 63048 22630 20926

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:

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:

1. Clinical notes dated 09/22/11-10/23/12
2. MRI lumbar spine dated 10/21/11
3. Prior reviews dated 09/11/12 and 10/12/12
4. Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury while pulling a dolly. The patient developed pain in low back radiating to left lower extremity. Initial MRI studies were stated to show disc bulging in lumbar spine. MRI of lumbar spine dated 10/21/11 revealed prior surgical changes compatible with partial discectomy at L4-5. A diffuse disc herniation approximately 3 mm was present at L4-5 indenting the thecal sac and contributing to moderate narrowing of neural foramina bilaterally. A large 8 mm subligamentous disc herniation L3-4 was noted causing severe narrowing of right lateral recess with posterior displacement and compression of exiting nerve root and moderate narrowing of central canal and mild narrowing of left lateral recess. The patient was recommended for laminectomy and discectomy at L3-4 with possible fusion L4-5 on 11/10/11. For unclear reasons this surgical procedure was not performed. Follow-up on 02/09/12 indicated the patient was not improving with medications; however, there was no indication what these medications were. Physical examination revealed no specific findings other than statements regarding bilateral radiculopathy. The patient was recommended to continue with current treatment; however, no specifications were made regarding what treatment this was going to be. Follow-up on 03/01/12 indicated the patient was taking Ibuprofen, Flexeril, and Tramadol without significant benefit. The patient continued to complain of severe low back pain radiating to lower extremities. The patient has utilized a TENS unit without significant benefits. As of 08/14/12, the patient was taking Hydrocodone which did address some of the patient's pain complaints; however, the patient continued to report low back pain radiating to the left lower extremity. Physical examination revealed straight leg raise at 40 degrees on left. The patient was continued on Lortab and Ibuprofen. Follow up on 09/27/12 stated the patient continued to have complaints of low back pain radiating to the left lower extremity with numbness and tingling in the left leg. Physical examination revealed hypoesthesia at an L5 dermatome to the left. No motor deficits or abnormal reflexes were reported. Straight leg raise was positive to the left at 45 degrees. The patient was recommended for lumbar laminectomy discectomy at L3-4 with laminectomy and possible fusion at L4-5. Follow up on 10/23/12 reported no significant change in the patient's symptoms. The request for lumbar laminectomy with possible fusion at L4-5 and a two day length of stay was denied by utilization review on 09/11/12. The reviewer opined that there was no specific motor group weakness or dermatomal decreases in sensation. There was no evidence of spinal instability to warrant spinal fusion and there was no indication and there was limited documentation regarding prior conservative treatment. No psychosocial screening was provided. The request was again denied by utilization review on 10/12/12 as there was limited documentation regarding prior conservative treatment and limited examinations regarding neurological deficits. No instability was documented and no psychosocial screening was reported.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL

BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for lumbar laminectomy and possible fusion at L4-5 with a two day length of stay is not recommended as medically necessary based on the clinical documentation provided for review. The clinical documentation does not establish what interval conservative treatment has been provided to the patient other than medications. There is no documentation regarding recent physical therapy or consideration for injections. The clinical documentation does reveal objective findings of a neurological deficit in the left lower extremity. However, the clinical documentation indicates the patient has been recommended for both the L3-4 and L4-5 levels for surgery. It is unclear why the request now is for the L4-5 level only. There is no evidence of any significant spinal instability at L4-5 to require lumbar fusion and no psychosocial screen was provided for review as indicated by and as recommended by current evidence based guidelines. As the clinical documentation provided for review does not support the request for surgical intervention, medical necessity would not be established.

IRO REVIEWER REPORT TEMPLATE -WC

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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. 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](#) ([Fisher, 2004](#))

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](#))

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).