

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/27/2012

**IRO CASE #:**

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

anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 with codes 22558, 22585, 22846, 22851 and 20931 with an assistant surgeon and a 3-day length of stay

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

M.D., Board Certified Orthopedic spine surgeon, practicing neurosurgeon

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** The reviewer finds medical necessity is not established for the proposed anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 with codes 22558, 22585, 22846, 22851 and 20931 with an assistant surgeon and a 3-day length of stay.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Notification of reconsideration adverse determination 09/06/12  
Notification of adverse determination/partial 06/13/12  
Claimant's appeal letter undated  
EMS records 06/23/11  
Emergency department records 06/23/11  
Operative report 06/27/11  
inpatient records 06/23/11-07/01/11  
Multiple imaging studies 06/23/11-05/23/12  
Carrier submission in response to IRO review 09/12/12  
Surgery follow up office visit 07/19/11 and 08/18/11  
Office visit notes 10/10/11-05/25/12  
Procedure note bilateral injection of S1 screw heads 01/27/12  
records 02/21/12  
Operative report reexploration of instrumentation and removal of S1 pedicle screws 02/21/12  
Electrodiagnostic studies 04/12/12  
Second opinion 05/08/12  
Procedure note lumbar facet block L5-S1 bilateral 05/17/12  
Emergency physician records 06/15/12  
Peer review 07/05/12  
Office visit note 07/31/12  
Designated doctor evaluation 08/23/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured on xx/xx/xx in a motor vehicle accident. This was a one vehicle rollover in which the claimant was thrown from the vehicle. Records indicate she had a brief loss of consciousness. She was transported by air to emergency department. Imaging studies revealed L4 spinal fracture with retropulsion without neurological sequelae, grade 3 to 4 right lobe of liver laceration contained.

On 06/27/11 claimant underwent decompressive laminectomy L4 and L5, reduction and stabilization of burst fracture with segmental instrumentation L2 to the sacrum and lateral mass fusion L3 to the sacrum, impactions of bone fragments with transpedicular approach with decompression of the thecal sac. Records indicate the claimant did relatively well following surgery. Lumbar spine x-rays were noted to demonstrate hardware from L2 to the sacrum, with burst fracture of L4 that appears to be healing. Decompression of L4 and L5 was noted with osteolysis around the sacral screws. The claimant continued to have back pain and it was felt that the probable pain generator was the lower screws. On 01/26/12, the claimant underwent bilateral injection of S1 screw heads, and the claimant experienced 100% relief for six to eight hours after the injection. On 02/21/12 the claimant underwent reexploration of instrumentation and removal of S1 pedicle screws. Claimant was seen on 05/08/12 for second opinion. It was noted the claimant is status post stabilization of L4 burst fracture on 06/27/11 with L2 sacrum stabilization. On 02/21/12 she had reexploration and instrumentation removal of S1 screws because of loose hardware. She has continued with low back pain. Currently she is having no leg symptoms. Electrodiagnostic testing on 04/12/12 reported evidence of mild subacute bilateral L5 and S1 radiculopathy slightly worse in the left. Neurological examination noted cranial nerves 2-12 grossly intact, motor exam 5/5, reflexes 1+ patellar, sensory intact, gait normal. recommended ultimately that further stability treated from posterior approach. His concern with anterior alone will be that this will not be enough stability for it because of long fusion. Lumbar facet block was performed on 05/17/12. The claimant was seen on 07/31/12. reviewed imaging studies, but no detailed physical examination was documented. He agreed with recommendation of doing 3 level anterior interbody fusion. The claimant underwent designated doctor's evaluation on 08/23/12. It was noted the claimant complains of daily aching and stabbing pain of back and head. She denies numbness and reported weakness of entire body. She denies bowel/bladder dysfunction since this injury. She denies sexual dysfunction since this injury. On examination gait was normal. Walking on toes and heels was performed without difficulty. Squatting was normal. Standing on one leg was normal. There was no tenderness to palpation, trigger points, or muscle spasms of paraspinal muscles. There is no pain with axial compression. There was 1+ midline tenderness to palpation of lumbar spine. Straight leg raise in supine position was 60 degrees bilaterally and 70 degrees bilaterally in seated position. Crossed straight leg raise was negative bilaterally. Hoover's was negative bilaterally. Sensation to pinprick and light touch was normal bilaterally. Knee and ankle jerks were 1/4 bilaterally. Muscle strength was 5/5 throughout bilateral lower extremities. The claimant had no positive Waddell's signs. determined the claimant had not reached maximum medical improvement. He noted she had burst fracture at L4-5 plus other compression fractures from motor vehicle accident, which required fusion surgery. She did well for a few months then developed low back pain. It was felt this was because of loosening of sacral screws, which were removed. After removal of sacral screws, the claimant developed more sense of low back pain below fusion level. Surgery was recommended because of loss of maturation of lateral mass fusion as well as pain below the level of fusion and fusion is going to be extended more distally. The claimant has had two other opinions, which have complied with opinion for further surgery.

A request for anterior lumbar interbody fusion L3-4, L4-5, and L5-S1 was non-certified per utilization review dated 06/13/12. The reviewer noted the claimant was injured secondary to a motor vehicle accident resulting in L4 burst fracture. The claimant underwent decompressive laminectomies at L4 and L5 and L2 to sacrum stabilization with re-exploration and instrumentation, removal of S1 screws. She continues to complain of low back pain with no lower extremity symptoms. MRI on 04/12/12 was markedly compromised and non-diagnostic. CT scan on 05/23/12 showed modification of posterior appliance fusion surgery

since prior examination of 12/19/11; stable appearance of burst fracture at L4; persistent evidence of a Schmorl's node in superior endplate structure of L2; no significant compromise of bony dimensions of the neural foramina or spinal canal. On examination gait was normal. Sensation was intact. Motor exam was 5/5. Reflexes were 1+ patellars.

A request for anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 was non-certified per utilization review dated 09/06/12. The reviewer noted that records submitted included MRI of lumbar spine dated 04/12/12, which demonstrates questionable L1-2 disc bulge and hyperintensity seen at L4-5 level. It is not clear if this is due to recent procedure or resolving hematoma. CT of lumbar spine dated 05/23/12 demonstrates there does not appear to be significant compromise of bony dimensions of neural foramina or spinal canal in lumbar spine. The burst fracture at L4 is stable. It was indicated there may be some minor disc bulging at L5-S1 without suggestion of focal herniated disc. Clinical examination of 05/08/12 demonstrated the claimant is neurologically intact. The clinic note of 07/31/12 did not discuss the physical examination. The records do not indicate psychological exam being performed. As such, guidelines indicate there should be documentation of instability or disc pathology in lumbar spine consistent with physical findings. There should be documentation of psychosocial evaluation, and there should be documentation of significant conservative treatment and documentation of all pain generators. As the records do not include psychosocial evaluation and do not indicate significant pathology in lumbar spine at this point in time in form of disc pathology and / or instability, the rationale for the procedure has not been demonstrated and request is non-certified.

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

The claimant was injured secondary to rollover motor vehicle accident resulting in L4 burst fracture. On 06/27/11 the claimant underwent decompressive laminectomy L4 and L5, with reduction and stabilization of burst fracture and segmental instrumentation L2-sacrum. The claimant initially did well following surgery, but subsequently developed low back pain without leg pain. There was evidence of loosening of sacral screws, and diagnostic hardware block provided 100% relief for 6-8 hours following procedure. The claimant then underwent reexploration of instrumentation with removal of S1 pedicle screws on 02/21/12. She developed increasing low back pain. MRI of lumbar spine on 04/12/12 noted the examination to be compromised due to metallic artifacts extending from L2-5 and spinal canal cannot be adequately assessed at this examination. For better evaluation post myelogram CT may be more beneficial. CT scan of lumbar spine on 05/23/12 was compared to prior study of 12/19/11 and noted modification of posterior spinal fusion surgery. The appearance of burst fracture at L4 is stable. There is persistent evidence of Schmorl's node in superior endplate structure of L2. There does not appear to be significant compromise of bony dimensions of neural foramina or spinal canal in lumbar region. On examination the claimant had no evidence of motor, sensory or reflex deficits. The records indicate the claimant had second and third surgical opinions which both concurred with recommendation for 3 level ALIF. However, there is no evidence of nonunion/pseudoarthrosis at any level of the lumbar spine on imaging, and no evidence of instability documented on flexion/extension views. Although did not include a physical examination in his evaluation on 07/31/12, the designated doctor's examination noted no motor or sensory changes. Given the clinical data provided, the ODG guidelines for the procedure have not been met and therefore, the reviewer finds medical necessity is not established for the proposed anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1 with codes 22558, 22585, 22846, 22851 and 20931 with an assistant surgeon and a 3-day length of stay.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-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)