



Specialty Independent Review Organization

DATE OF REVIEW: 12/24/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include an anterior decompression with partial vertebrectomy @ L4/5 followed by an interbody fusion

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

The reviewing physician is a Medical Doctor who is board certified in Orthopedic Surgery and has been practicing for greater than 15 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 agrees with the previous adverse determination regarding all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: LPT, the URA, the carrier, Dr., Dr. and from the patient.

These records consist of the following (duplicate records are only listed from one source): Carrier: TDI notice of assignment, Request for IRO, Preauthorization Review Summaries – various TWCC 73 forms, 8/8/07 lumbar discogram with post CT, various labwork results, notes from 4/12/07 to 8/3/07, notes from 6/22/07 to 7/23/07, PT treatment encounter notes 3/22/07 to 7/16/07, exercise flow sheets 6/29/07 to 7/16/07, notes by 3/22/07 through 6/28/07, 6/1/07 lumbar myelogram with post CT, 5/30/07 lumbar myelogram, preauth requests and operative report 5/8/07.

Patient records consisted of: 12/7/07 letter and an October 2, 2007 evaluation by, DO.

Dr. records consist of: 3/7/07 lumbar MRI, 4/12/07 radiology report and notes by 8/3/07 to 11/28/07.

LPT records consist of: 7/17/07 letter to Dr.

Dr. records consist of: 8/9/07 report by MD.

The URA records consist of: 5/30/07 report by MD, 8/27/07 to 9/14/07 reports MD,

We did not receive a copy of the ODG from the carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

xx year of age male who was injured pulling on a large wrench when he felt a pop and instant back pain. Patient worked light duty until 6/07 when back pain worsened. He now complains of lumbar pain and right leg pain and numbness. On 3/7/07 MRI LS – L4/5 with slight desiccation & left sided protrusion. A Lumbar ESI was performed on 5/8/07 without significant benefit.

On 5/30/07 CT post myelogram indicated under filling L>R L5 n. root, mild bulge L45 without canal compromise. On 6/1/07 an EMG/NCV indicated RLE nl. The 8/9/07 discogram L2/3 nl; L3/4 pressure s pain, annular tear; L4/5 10/10 pain partial concordant back only, annular tear; L5/S1 10/10 pain partial concordant back only, no tear; negative Marcaine challenge.

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

According to the ODG, 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. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. 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. While not recommended above, if a decision is made to use discography anyway, the following criteria should apply:

1) Back pain of at least 3 months duration 2) Failure of recommended conservative treatment including active physical therapy 3) An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection) 4) Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided) 5) Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive)

NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However, all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria.

- o Briefed on potential risks and benefits from discography and surgery
- o Single level testing (with control) (Colorado, 2001)

This patient does not meet the ODG criteria for this surgical procedure; therefore, the surgery is not medically necessary at this time.

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 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)