

# Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

## **DATE OF REVIEW:**

DECEMBER 26, 2007

## **IRO CASE #:**

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

Removal of old hardware L4/5 and L5/S1 with decompression and dynamic stabilization rods to L3/4 with a three 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 Surgeon

## **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)

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

No ODG Guidelines

Office notes, Dr., 05/11/06, 08/03/06 and 06/14/07

MRI lumbar, 06/01/06

CT / Myelogram, 06/23/06

Dr. / Designated Doctor Examination, 06/19/07

Psychological Evaluation, 11/14/07

Peer Reviews, 10/06/06, 11/08/07 and 11/27/07

Letter from, 06/25/07

Letter from Dr., 03/19/07 and 07/31/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This xx year old female claimant reportedly underwent an anterior- posterior two level lumbar fusion in xxxx. The claimant reportedly did well post-operatively until back and right leg pain was reported in 2006. X-rays of the lumbar spine in 2006 showed a two level solid fusion with hardware intact. A CT/myelogram on 06/23/06 showed constriction at the level above the old fusion. Removal of the old hardware and use of global rods to extend the fusion to L3-4 along with decompression at L3-4 was recommended. A physician evaluation dated 06/14/07 noted the claimant with persistent back and left side numbness. There was diminished range of motion on examination secondary to pain, spasm and stiffens. The claimant was diagnosed with junctional disease at L3-4 and the previous surgery recommended was requested.

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

In this dispute resolution removal of hardware at L4-5 and L5-S1 with decompression, dynamic stabilization rods at L3-4 with a three day length of stay does not appear to be medically necessary or appropriate.

This is a xx-year-old female who in xxxx underwent anterior and posterior spinal fusions at L4-5 and L5-S1. She has had pain and dysfunction. She has had hardware injections noted, but the response to these has not been documented. CT lumbar spine post myelogram demonstrates an L3-4 mild disc bulge and mild spinal stenosis at L4-5 and L5-S1, metallic artifact limits the assessment. On 06/19/07 clinical examination demonstrates occasional numbness about the lower extremity and degenerative disc disease worse over the last 16 years after lumbar spine fusion, spasm was appreciated and an intact neurologic exam was noted. Upon review of the medical records, no conservative measures have been documented other than the hardware injection for which the results are not documented. The amount of impairment this is causing upon this claimant has not been well documented as this claimant has returned back to work. Based on this lack of information, the Reviewer does not think that it is reasonable and appropriate to proceed with the above mentioned procedure.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back Fusion (spinal)

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy.

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion

**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 disectomy. [

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. [

)] (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.

**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)**