

SENT VIA EMAIL OR FAX ON
Dec/03/2008

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/01/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpt lumbar laminectomy with fusion and 1 day LOS; LSO back brace

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 10/7/08 and 10/23/08

Records from Dr. 12/27/07 thru 10/13/08

OP Report 5/21/08 and 4/29/08

Radiology Reports 4/29/08 and 1/28/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year-old male with a date of injury in xx/xx/xx after pulling a pipe out of a hole. He developed the onset of low back pain with radiating left leg pain. He was diagnosed with a left L4 and L5 radiculopathy secondary to a large left L4-L5 herniated disc. On 09/04/2007 he underwent decompression and excision of the disc, with resolution of the left leg pain. He did get PT postoperatively. In 02/2008 he complained of mechanical back and right leg pain. A lumbar myelogram and CT 04/29/2008 showed central and bilateral L4-L5 defects with bulging at L4-L5 with neuroforaminal involvement. There was L5-S1 mild central disc bulging. The claimant underwent an ESI 05/21/2008 with some benefit. He is on multiple

medications. On 09/28/2008 the claimant was found to have weakness of ankle dorsiflexion bilaterally with decreased sensation in the L5 dermatome. A post-myelo CT 04/29/2008 shows broad bulging of the disc causing mild encroachment upon the anterior aspect of the dural sac and neuroforamina. The provider is recommending lumbar laminectomy with fusion and instrumentation at L4-L5 with a one night admission and purchase of a TLSO brace.

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

This injured worker appears to have mechanical back pain as well as bilateral L5 weakness. He has failed some conservative measures, and the provider is wishing to perform a decompression and fusion at L4-L5. A decompression, alone, would help with the radicular component, but the claimant might be left with continued back pain. According to the Occupational and Disability Guidelines, "Low Back" chapter, a psychosocial screen, with confounding issues addressed, should be done prior to a lumbar fusion. There is no evidence that this has been one for this particular case. Therefore, based on the submitted documentation, the proposed surgery is not medically necessary.

References/Guidelines

ODG "Low Back"

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. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (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. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (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 disectomies on the same disc, fusion may be an option at the time of the third disectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Disectomy.

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. (Colorado, 2001) (BlueCross BlueShield, 2002)

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)