

SENT VIA EMAIL OR FAX ON
Dec/31/2008

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/31/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5, L5/S1 discectomy/fusion/instrumentation LOS

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)

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year-old male with a date of injury xx/xx/xx, when he was struck in the back by a fork lift. He complains of back pain, radiating to the bilateral legs, right much more so than left. He has had physical therapy. His neurological examination reveals a positive straight-leg raising on the right with weak ankle plantar flexion, dorsiflexion and knee extension on the right. There is sensory loss at L4-S1 on the right with an absent right knee jerk reflex. Electrophysiologic studies 08/06/2008 are normal. MRI of the lumbar spine 06/26/2008 reveals small annular tears at L4-L5 and L5-S1, with small central disc herniations and degenerative changes of articulating facets.

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

The L4-L5 and L5-S1 discectomy and fusion are not medically necessary. Firstly, the MRI findings are quite mild, and it is unclear as to whether facet etiology of his pain has been looked into, given that some facet pathology is seen at these levels. Therefore, it is unclear that all pain generators have been identified and treated. Secondly, according to the ODG, a psychosocial screen should be done, with all confounding issues addressed, prior to a lumbar fusion. Although there is documented weakness and reflex changes on examination, there is no evidence of neural compression on the MRI and the electrophysiologic studies are normal. This is not an emergency situation, and further investigation needs to be done prior to the

claimant's undergoing a two-level fusion.

References/Guidelines

2008 Official Disability Guidelines, 13th edition

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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