



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 2/12/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the concurrent medical necessity of an anterior interbody fusion at L4-L5, L5-S1 and a Cybertech TLSO back brace.

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 the concurrent medical necessity of an anterior interbody fusion at L4-L5, L5-S1 and a Cybertech TLSO back brace.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Dr

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from Dr.: Request for Preauthorization for surgery – 11/4/07; Testing and Recommendations – 9/5/07; Diagnostic Interview and Recommendations – 9/5/07; Chart notes – 10/16/07-8/13/07; Imaging MRI lumbar spine report – 8/1/2005; and Imaging MRI lumbar spine w/o contrast report – 7/6/2004.

Records reviewed from: denial letter – 1/3/08, Reconsideration denial – 1/17/08, PRA Referral Form – 1/15/2008; medical necessity report – 1/15/08; Pre-certification Request Form – 9/11/2007 and Notice of Non- Certification –

11/14/2007; and Spine Care Demographic and Workers' Compensation Data Sheet – 11/2007.

A copy of the ODG Guidelines was not provided for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a xx-year-old female who sustained an injury to her back in an automobile accident xx/xx/xx. An MRI shows disc bulges and desiccation without herniation or stenosis. No instability is proven. Psych evaluation reveals untreated depression and anxiety.

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

According to the OD Guidelines: Indications for spinal fusion 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 discectomy. [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 discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)

The patient has no neural arch defect, instability demonstrated, previous surgery, infection tumor or deformity. She does have an active psych diagnosis and has

greater than 6 month disability. Therefore the anterior interbody fusion at L4-L5, L5-S1 and a Cybertech TLSO back brace is not medically necessary.

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)