

Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of anterior lumbar discectomy L4-5 lumbar fusion interbody L4-5, caging, grafting.

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

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

ODG Guidelines

CT cervical, thoracic and lumbar spine, 01/02/06

Chest X-ray, 01/02/06

X-ray pelvis, 01/02/06

MRI lumbar, 03/07/06

Consult, Dr., 03/28/06

Procedure reports, 05/31/06, 06/21/06, 06/26/06

Office notes, Dr., 09/07/06, 11/30/06, 02/13/07, 05/08/07

Lower extremity evaluation, 12/18/06

FCE, 04/19/07

Office note, Dr., 04/19/07

Office note, Dr., 08/14/07

FCE letter, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old female reportedly was involved in a motor vehicle accident on xx/xx/xx while working as a xxxx. The records indicated that the injury resulted in lower back and left leg pain. The claimant was initially diagnosed with a lumbar sprain and treated conservatively with medication and physical therapy. A lumbar MRI done on 03/07/06 showed severe stenosis at multiple levels.

Persistent lower back and left leg pain was noted and the claimant underwent a series of three epidural steroid injections in May and June 2006 with no lasting relief. The claimant was diagnosed with multilevel foraminal stenosis and spinal stenosis at L2 through S1, degenerative scoliosis, lumbar radiculopathy and low back pain. Treatment options were discussed and a lumbar laminectomy and fusion was recommended.

The requested surgery was denied and the claimant continued to treat conservatively. A Required Medical Evaluation performed on 08/14/07 revealed the claimant with continued lower back greater than diffuse leg pain. There were no abnormal neurological findings in either lower extremity on physical examination. The physician surmised that symptoms were lumbar mechanical in origin and diagnosed spondylogenic lumbosacral spine pain, chronic, anatomic etiology undetermined. In addition, the physician noted there was no basis for the proposed surgery given the claimant's advanced age, longstanding multilevel degenerative changes and no clear imaging of specific spinal stenosis.

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

The requested L4-5 lumbar fusion does not appear medically necessary based on a careful review of all medical records. The records are somewhat confusing given the conflicting data provided by Dr., the treating spine surgeon, and Dr. the independent evaluator. Dr. reports the MRI shows multilevel severe stenosis and Dr. reports the MRI shows no clear specific spinal stenosis. The actual MRI report from the radiologist states multilevel degenerative disc disease with bulging and borderline stenosis. The claimant appears to have a normal neurological examination. It is unclear why an initial decompression and fusion was recommended over an extended region from L2 through S1. This revised request now to an L4-5 fusion maybe secondary to the grade I spondylolisthesis at that level. However, there is no mention of flexion/extension X-rays to confirm any true dynamic instability at that level. The claimant does not appear to have lumbar radiculopathy. For all these reasons, the Reviewer is unable to justify the surgical request as stated based on a careful review of all medical records.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Fusion.

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

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 discectomy.

(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).

(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

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- 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)