TMF
Health Quality Institute

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Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 06/12/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior and posterior spinal fusion L4-S1 with instrumentation, purchase of LSO brace and external bone growth stimulator

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the anterior and posterior spinal fusion L4-S1 with instrumentation, purchase of LSO brace and external bone growth stimulator are not medically indicated to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice of review outcome: initial adverse determination/denial – 04/18/08
- Physician Advisor Report– 04/18/08, 05/06/08

- Notice of reconsideration outcome – Adverse determination – 12/22/04, 05/07/08
- Notice to TMF Health Quality Institute of Case Assignment – 05/19/08
- Letter to TMF from attorneys – 05/23/08
- Office visit notes by Dr. – 03/08/08 to 03/11/08
- Operative Report – 01/04/05, 03/09/05, 05/16/05, 11/16/07
- Report of MRI of the lumbar spine – 09/10/04, 08/24/07
- Report of lower extremity electromyography studies – 08/29/07
- History and Physical by Dr. – 10/19/07
- Office visit notes by Dr. – 12/07/07
- Copy of ODG Treatment Guidelines, Low Back, Fusion, Bone Growth Stim. Brace – no date
- Information for requesting a review by an IRO – 05/13/08
- Letters of medical necessity by Dr. – 02/21/05, 09/29/04, 07/18/05, 04/29/04
- Report of nerve conduction studies by Dr. – 02/21/05
- Report of spinal ultrasound by Dr. – 02/21/05
- Notice of outcome of preauthorization – 03/03/05
- Office visit progress notes by Dr. – 08/31/04 to 01/26/06
- New patient consultation by Dr. – 04/14/05, 05/27/05
- Preauthorization request for diskectomy – 05/05/05
- Office visit notes by Dr. – 12/09/04 to 03/17/05
- Report of CT scan of the lumbar spine – 03/09/05
- Follow Report by The Group Inc. – 11/15/04 to 11/02/05
- Preauthorization request for discogram – 03/01/05
- Page 2 of operative report by Dr. – no date
- Independent medical evaluation by Dr. – 12/03/04 to 09/27/05
- Request for preauthorization for Work Hardening – 12/15/04, 02/01/05
- Work Hardening daily notes – 01/13/05 to 11/09/05
- Request for preauthorization for facet injection – 01/18/05
- RX for physical therapy – 11/15/04
- Designated Doctor Evaluation – 12/22/04, 07/18/06
- Office visit notes by Dr. – 10/04/04 to 01/12/05
- PEER Review Analysis – 12/16/04
- Initial Review by LPC – 11/02/04
- Functional Capacity Evaluation – 10/04/04, 12/10/04, 12/15/04, 09/08/05, 02/21/06, 09/10/07
- Report of Lumbar Spinoscopy – 12/21/04
- Initial Report by Dr. – 10/14/04
- Progress notes– 10/04/04 to 10/29/04
- Initial examination by Dr. – 09/27/04
- Initial office visit by Dr.– 09/04/02
- Spine evaluation by Dr. – 08/30/07
- Review of designated Dr. Examination by Dr. – 08/29/06

- Report of Medical Evaluation by Dr. – 04/24/06
- Peer Review Report – 12/29/05, 03/06/06
- Mental Health Evaluation – 02/16/06
- Consultation by Dr. – 01/12/06
- Manual Muscle Test of lumbar spine – 10/14/08
- Physical performance evaluation – 10/27/05

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury when she suffered a fall. She was evaluated and treated by a local chiropractor with physical therapy. She was evaluated by a local orthopedic surgeon and an MRI revealed herniated nucleus pulposae at L4-L5 and L5-S1. A two level laminectomy discectomy was performed 05/06/05 and she failed to improve. She remains symptomatic. She has been evaluated by a number of orthopedic spine surgeons, chiropractors, pain management specialists and occupational medicine specialists. She had MRI's, EMG/NC studies, a discogram (2005), multiple medications, and epidural steroid injections. She has had a number of designated doctor evaluations and medical record reviews. Most recently, the treating physician has recommended anterior and posterior instrumentation lumbar fusion, application of a bone growth stimulator, and use of an LSO.

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

This patient has a long history of chronic low back pain. The surgery being considered and requested for pre-authorization has a high potential for less than acceptable results for this patient. The patient has number of factors which would lead one to believe she clearly has a less than 50% chance of an acceptable result. In the absence of a demonstrated instability, the anterior and posterior instrumented fusion would not be indicated.

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. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Anderson 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 4.5mm). (Anderson 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 not be an option at the time of the third discectomy, which should also meet ODG criteria. (See ODG Indication for Surgery – Discectomy.)

Pre-Operative Surgical Indication Recommended: Pre-operative indication 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)