



Notice of Independent Review Decision

DATE OF REVIEW: 5/19/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cage, posterior instrumentation, implantation of a bone growth stimulator at L4-5, with a 2-day length of stay.

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

Texas licensed neurological 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)

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.

Approved health care services: The previously denied request for inpatient lumbar surgery to include lumbar laminectomy, discectomy, arthrodesis with cage, posterior instrumentation, implantation of a bone growth stimulator at L4-5, with a 2-day length of stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax Cover Sheet dated 5/15/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 5/15/08.
- Treatment Request dated 5/7/08, 4/30/08.
- Notice to CompPartners, INC of Case Assignment dated 5/15/08.
- Notice of Assignment of Independent Review Organization dated 5/15/08.
- Confidential Information (unspecified date).
- Office Visit dated 2/26/08.
- Electrodiagnostic Examination dated 3/1/07.
- Lumbar X-ray dated 10/19/07.
- Psychological Evaluation dated 4/18/08.

No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Motor vehicle accident.

Diagnosis: Lumbar disc herniation with radiculopathy.

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

This female had a date of injury of xx/xx/xx. The mechanism of injury was a motor vehicle accident. The claimant complained of excruciating back and right leg pain. According to the provider, the claimant had extensive physical therapy, as well as medications and injections. Electromyogram/nerve conduction velocity (EMG/NCV) studies on 03/01/2007, revealed an L5 and S1 radiculopathy. Neurological examination revealed decreased knee jerk bilaterally; absent posterior tibial tendon bilaterally, parasthesias in the L5 and S1 distribution on the right, and weakness of extensor hallucis longus and gastroc-soleus on the right. An MRI of the lumbar spine on 10/19/2007 revealed a diffuse disc bulge at L4-L5, with flattening of the thecal sac and mild bilateral foraminal encroachment. There was disc dessication at this level as well. A psychological evaluation found her to be a fair risk for spinal surgery. The claimant is obese and is a smoker. The provider is recommending an L4-L5 laminectomy, discectomy, arthrodesis with a cage, and posterior instrumentation with a bone growth stimulator and 2-day length of stay.

The examination under anesthesia is not medically necessary. There is no evidence that this examination will affect the claimant's outcome or provide a health benefit to the claimant. The ODG do not mention this procedure, nor could this reviewer find any references in the peer-reviewed medical literature to support its use.

The decompression, laminectomy and discectomy, are medically necessary. The claimant had neurological signs and symptoms referable to that level, and this procedure should be done in conjunction with, and be considered part of, the fusion. The lumbar fusion is medically necessary. The claimant had severe, refractory pain, and showed marked degenerative changes, primarily at this level. She meets the ODG criteria for lumbar fusion. Conservative therapy has been completed, pain generators have been identified and treated, and she has had a psychological evaluation. A 2-day length of stay is reasonable for a one-level lumbar fusion. This is consistent with Milliman Guidelines.

Other CPT codes not medically necessary: discography 62290 reduction of subluxation 22325. There was no evidence that these two procedures are medically necessary for this clinical situation. The ODG, "Low Back" states, *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). (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. (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. A bone growth stimulator and its associated CPT codes, is medically necessary.*

The claimant is a smoker, which places her in a "high risk" category for nonunion. A pseudoarthrosis can cause chronic pain and need for additional surgery. According to the ODG, there is some evidence to show the efficacy of a bone growth stimulator in those patients who are considered high risk for nonunion. ODG Low back--Bone growth stimulator states "Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker)."

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
“Lumbar Fusion”
- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), Treatment Index, 6th Edition (web), 2008, Low back—
Laminectomy/Discectomy.
Fusion.
Bone growth stimulators.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).