

C-IRO, Inc.
An Independent Review Organization
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Austin, TX 78726

DATE OF REVIEW: NOVEMBER 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient Lumbar Surgery to include Revision Lumbar Laminectomy Discectomy, Arthrodesis with Cages, Internal fixation, Reduction of Spondylolisthesis, and Implantation of Bone Growth Stimulator at L4/Transitional Level with 2 Days LOS

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

MD, Board Certified Neurosurgeon

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.

The reviewer finds that medical necessity does not exist for Inpatient Lumbar Surgery to include Revision Lumbar Laminectomy Discectomy, Arthrodesis with Cages, Internal fixation, Reduction of Spondylolisthesis, and Implantation of Bone Growth Stimulator at L4/Transitional Level with 2 Days LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/23/08, 10/31/08
ODG Guidelines and Treatment Guidelines
MD, 9/23/08
Dr. MD, 6/19/08
X-ray report MD, 2/11/03
MRI of Lumbar Spine with and without contrast, 8/9/02, 10/28/99, 7/24/01
MD, 8/13/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male with a date of injury xx/xx/xx. He has had 4 prior lumbar surgeries, including a fusion from L4 to S1, the most recent in 2002. He still complains of low back and bilateral leg pain, worse on the right than the left. His neurological examination reveals decreased sensation in the L5 and S1 distribution in both legs. There is 4/5 weakness in the extensor hallucis longus on the right, as well as the tibialis anterior and gastrocnemius on the right. Flexion and extension lumbar films reportedly revealed an obvious pseudoarthrosis at L4 with a 12mm spondylolisthesis at the L4 level. An MRI of the lumbar spine reportedly shows a retrolisthesis at L2-L3, L4-L5, and L5-S1.

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

Based on the submitted documentation, the surgery is not medically necessary. The most recent MRI report submitted is from 08/09/2002. In addition, the x-ray report demonstrating the spondylolisthesis is also not included. According to the ODG, there should be corroboration between the clinician findings and imaging findings. This cannot be assessed without the above reports. Also, it is unclear which levels the provider is planning to perform surgery upon. The reviewer finds that medical necessity does not exist for Inpatient Lumbar Surgery to include Revision Lumbar Laminectomy Discectomy, Arthrodesis with Cages, Internal fixation, Reduction of Spondylolisthesis, and Implantation of Bone Growth Stimulator at L4/Transitional Level with 2 Days LOS.

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 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.) 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)