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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation at L5-S1.

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines
Chiro visits, Dr. , 03/08/99 – 06/12/00, 06/19/00 – 08/03/01, 09/14/01-11/27/02
Exam, Dr. , 05/03/00
Medical examination, Dr. , 08/21/01
Visit, Dr. , 04/19/04, 05/10/04, 05/17/04
OP report, 05/21/04, 06/09/04
PT notes, 11/22/04 and 12/16/04
Office notes, Dr. , 09/05/06, 05/13/08, 07/29/08
MRI lumbar, 07/28/08
EMG, 09/9/08
Review, 09/10/08
Behavioral health assessment, Counselor, 01/19/09
Peer review, Dr. , 03/19/09
Peer review, Dr. , 03/26/09

PATIENT CLINICAL HISTORY SUMMARY
This is a xx year-old female who sustained an injury on xx/xx/xx when she slipped and fell. She had an onset of pain that continued to worsen. She began chiropractic treatments with Dr. starting on 03/08/99 and going through 11/27/02 for complaints of migraine headaches, neck pain and lower back pain. Conservative chiropractic care was initiated at that time and an x ray obtained which showed a transitional lumbosacral segment.

On 04/19/04 the claimant was seen by Dr. , an orthopedic surgeon. The claimant continued with complaints of neck and lower back pain. Dr. ordered an MRI of both the cervical and lumbar spine on 05/12/04 which revealed cervical degenerative and disc disease, and lumbar spondylolysis with a grade I spondylolisthesis. The claimant was treated conservatively with epidural steroid injections that were done on 05/21/04 and physical therapy.

On 09/05/06 the claimant was seen by Dr. who diagnosed the claimant with multi-level cervical herniated nucleus pulpous and lumbar spondylolisthesis of the last open disc space and recommended exercise and repeat epidural steroid injections. On 05/13/08 the claimant was seen again by Dr. for continued pain but also with a new complaint of bladder problems. An MRI of the lumbar spine performed on 07/28/08 revealed bilateral L5 spondylolysis with grade I spondylolisthesis at the L5-S1 level. Diffuse bulging of the L2-3 disc resulting in borderline spinal stenosis and a small left posterolateral annular tear of L2-3 was noted. The Cervical spine portion of the MRI revealed a moderate diffuse bulging of C6-7 and moderate mild cervical spondylosis. Diagnosis at that time was cervical herniated nucleus pulpous with radiculopathy and lumbar herniated nucleus pulpous with instability with some cauda equina symptoms and recommendation for surgical intervention. The electrodiagnostic exam done on 09/09/08 was normal.

A pre surgical psychological exam was completed on 01/19/09 and it was noted that there was no need for further psychological testing. The claimant was stable enough to proceed with surgery. On 03/19/09 and 03/26/09 the requested surgery was denied. Recommended surgery was for examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, and posterior instrumentation at L5-S1.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
This request for L5-S1 fusion meets ODG criteria. The claimant has pathology at the L5-S1 level by MRI. She has a documented spondylolisthesis at that level, suggesting spinal instability. A psychosocial screen notes no confounding issues.

The claimant has failed conservative measures of care and stabilization of the potentially unstable segment meets the guidelines. The reviewer finds that medical necessity exists for Inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation at L5-S1.Official Disability Guidelines Treatment in Worker's Comp 2009 Updates – low back

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 diskectomy. [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-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)