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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. 22842 Insert spine fixation device
2. 63090 removal of vertebral body
3. 22612 Lumbar spine fusion
4. 22558 Lumbar spine fusion
5. 22851 Apply spine prosthetic device
6. 20931 Spinal bone allograft
7. 63047 Removal of spinal lamina

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)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

1. 22842 Insert spine fixation device - OVERTURNED
2. 63090 removal of vertebral body - UPHELD
3. 22612 Lumbar spine fusion - OVERTURNED
4. 22558 Lumbar spine fusion - OVERTURNED

5. 22851 Apply spine prosthetic device - OVERTURNED

6. 20931 Spinal bone allograft - OVERTURNED

7. 63047 Removal of spinal lamina - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

PT notes, 03/30/07

Office note, Dr., 04/23/07

MRI lumbar spine, 5/17/07

Office notes, Dr08/13/07, 09/14/07, 10/17/07, 01/09/08, 02/13/08, 04/08/08

Letter, Dr, 10/17/07

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

Operative report, Dr., 04/19/08

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, low back, fusion

ODG- Patient Selection Criteria for Lumbar Spinal Fusion

PATIENT CLINICAL HISTORY SUMMARY

This is a female with chronic low back and left leg pain. The MRI of the lumbar spine from xx-xx-xx showed no evidence of disc herniation or significant disc bulging or spinal or foraminal stenosis. There was some very mild disc bulging with some very mild L3-4 foraminal reduction. Dr. evaluated the claimant on 08/13/07. The claimant reported numbness and tingling and burning over entire left leg and low back pain radiating from the left buttock into the left greater trochanter. The claimant reported the pain was worse with physical therapy and she had some minimal relief with injections. Examination revealed diminished reflexes bilaterally; antalgic gait favoring left lower extremity, tenderness and fabere testing aggravated her left hip pain. X-rays of the lumbar spine that day showed slight lean to the left, some mid degenerative changes including some lateral osteophytes on the left at L2-3 and L3-4, very obvious pars defects at the L5 level which was worse on the left than on the right. Sacroiliac joints had some mild sclerosis bilaterally but otherwise unremarkable. Lateral films revealed normal anterior and posterior longitudinal alignment that was stable on flexion and extension. Disc heights were well maintained. There were some very mild anterior osteophytes at most levels except L3-4 which was well preserved. There was significant sclerosis in the L5-S1 facets and modestly at L4-5. Bone mineral density appeared mildly osteopenic. Dr noted that the 06/22/07 nerve test by Dr. suggested some mild left L4 changes and upon further review Dr. noted it appeared to be mostly due to some polyphasic activity in some of the L4 musculature, no axonal injury and if these changes that the claimant was noting were truly clinically relevant this would suggest a subacute radiculopathy with some ongoing reinnervation. A pars defect injection, referral to orthopedic for knee complaints and Darvocet were recommended. On 09/14/07, the claimant reported 30 percent improvement for 3 days following the 08/30/07 pars injection. On 10/17/07, Dr. noted that the claimant had 90 percent relief in her leg symptoms following the nerve block. Dr. referred the claimant to pain management psychologist and referred to ortho spine for surgical options. Dr. evaluated the claimant on 11/06/07. Examination revealed diminished sensation in the L5 distribution on left, tender range of motion with radiating pain into the groin and down the leg with positive straight leg raise at about 50 degrees. There was weakness in the extensor hallucis longus. Diagnosis was spondylolysis L5 bilaterally, L5 radiculopathy and failed conservative care. Dr. felt that the MRI showed mild degenerative changes with pars defect on far sagittal exam and which was readily seen on the office x-rays previously. Dr. noted that the electromyography was read as an L4 distribution but did have overlapping of the L5 region. Dr. recommended an minimally invasive fusion at L5-S1 with pedicle screw fixation posteriorly and axial fusion L5-S1 and a psychological evaluation. On 01/09/08, Dr. evaluated the claimant for worsening of her leg and groin pain. Sensation and reflexes were intact. She was using a cane. Dr documented some pain limitations with strength testing in the proximal left leg. Lyrica, Darvocet and off work was recommended. Dr. performed a 04/19/08 anterior lumbar interbody fusion L5-S1, placement of surgical reconstructive cage at L5-S1, procurement and utilization of morcellized autograft same incision for spinal fusion at L5-S1 and utilization of infuse bone morphogenic protein for spinal fusion.

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

The claimant has an L5-S1 spondylolisthesis with mechanical back and referred leg pain. She has failed to respond to conservative treatment. She underwent a fusion.

The items in dispute are:

1. 22842 Insert spine fixation device – OVERTURNED. Insertion of spinal fixation device was indicated. She failed to respond to conservative treatment and required a fusion.
2. 63090 removal of vertebral body – UPHeld. There is no justification for a corpectomy. I did not have the operative note for review. The claimant may have required a discectomy, but it does not appear that she underwent a corpectomy.
3. 22612 Lumbar spine fusion – OVERTURNED. Lumbar fusion appeared to be approved. She had mechanical back pain due to an L5-S1 spondylolisthesis/spondylolysis and had failed to respond to conservative treatment.
4. 22558 Lumbar spine fusion – OVERTURNED. See above.
5. 22851 Apply spine prosthetic device – OVERTURNED. Application of spine prosthetic device would be approved for a fusion.
6. 20931 Spinal bone allograft – OVERTURNED. Use of a bone allograft is appropriate for an L5-S1 fusion.
7. 63047 Removal of spinal lamina – OVERTURNED. Removal of spinal lamina is appropriate due to her spondylolisthesis.

In summary, the patient had mechanical back as well as leg pain. She failed to respond to conservative treatment thus requiring a decompression and fusion. She failed appropriate conservative treatment. All of the above appear to be indicated with the exception of the removal of the vertebral body which was not justified in the information reviewed.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, low back, fusion

ODG- Patient Selection Criteria for Lumbar Spinal 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, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Studies conducted in order to compare different surgical techniques have shown success for fusion in carefully selected patients.

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

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)