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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator at L3, L4, and L5 with inpatient LOS for two days

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Office notes, Dr. , 10/14/08, 10/24/08, 12/03/08, 02/25/09, 04/21/09

EMG/NCV, 11/10/08

CT L/S, 2/8/09

Office notes, Dr. , 3/11/09, 06/15/09

Procedure, Dr. , 4/28/09

Office note, 5/20/09

Office note, Dr. , 7/14/09

Peer reviews, 7/21/09, 07/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx-year-old female reportedly injured when she fell on steps on xx/xx/xx. An office note from Dr. on 10/14/08 noted the claimant underwent lumbar spinal fusion at L4-5 with revision fusion and placement of a bone growth stimulator. The surgery provided no significant relief of her lower back and right lower extremity pain. Exam findings noted decreased muscle motor strength in the right lower leg with positive right straight leg raise and diminished right Achilles reflex.

Electrodiagnostic studies on 11/10/08 noted findings consistent with chronic right L5 and S1 radiculopathy in the right and clinical signs for sensory S2 and S3 bilateral radiculopathies with a subtle finding for L5 chronic radiculopathy on the left.

A lumbar CT scan on 02/08/09 noted an anterior /posterior solid fusion at L5-S1 with a large right paracentral ossification compressing the left S1 nerve root and a large right L5 superior articular process osteophyte compressing the right L4 nerve root. At L3-4, there was a disc bulge with impression and posterior displacement on the left L3 nerve root.

Dr. saw the claimant on 03/11/09. His impression was post L5-S1 fusion, solid, with L4-5 facet arthropathy and L4-5 internal disc derangement. On 04/28/09, bilateral L3-4 and L4-5 median nerve branch blocks were administered with no reported relief. An office visit on 06/15/09 noted complaints of constant pain and an antalgic gait. X-rays reportedly showed interbody fusion at L5-S1 with indication of segmental instability at L2-3 and L3-4. Lumbar surgery was recommended and a psychometric pre-surgical screening was suggested.

The most recent office examination by Dr. on 07/14/09 noted failed lumbar spine syndrome with progressive and increasing back and right leg pain. Dynamic lumbar films noted laminotomy at L5-S1 on left, incomplete, with inner body arthrodesis and lateral arthrodesis at L5-S1 well healed. The L4-5 extension angle was abnormal at 20 degrees with facet subluxation and foraminal stenosis. At L3-4, the extension angle was to 21 degrees with facet subluxation and foraminal stenosis and lateral recess stenosis. L2-3 level was within normal limits. Objective findings noted bilateral sciatic notch tenderness, positive flip test, and extensor lag. Laseque's and Bragard's were positive on the right with decreased right knee reflex, absent right ankle reflex and absent posterior tibial tendon reflexes bilaterally. Paresthesia was noted in the right L4, L5 and S1 nerve root distribution with muscle motor testing decreased in the right lower extremity muscle groups. The impression was failed lumbar spine syndrome with incomplete decompression L5-S1 with adjacent segment disease L4-5, L3-4 consistent with clinical instability pattern. Surgery with complete decompression L5-S1 with decompression stabilization, arthrodesis, internal fixation L3-4, and L4-5 with bone growth stimulator was recommended.

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

The requested revision fusion with fusion of two above levels cannot be justified as medically necessary based on the information reviewed. Two previous practitioners have indicated that the claimant's prior L5-S1 fusion has healed. It is not clear from the records provided if the claimant has instability on dynamic flexion/extension views. Though a psychological evaluation was recommended at one point, records do not indicate that one has been performed. The records are not clear what type of nonoperative conservative treatment has been rendered. For all of these reasons, the surgical request does not currently meet appropriate ODG criteria for the requested surgery. The reviewer finds that medical necessity does not exist for Revision lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of a bone growth stimulator at L3, L4, and L5 with inpatient LOS for two days.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, 14th Edition, Low Back

ODG Indications for Surgery| -- Discectomy/laminectomy -

Required symptoms/findings; imaging studies; & conservative treatments below

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. (Andersson, 2000) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging

Findings require ONE of the following

A. L3 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps weakness
3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following

1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following

- A. Activity modification (not bed rest) after patient education (\geq 2 months)
- B. Drug therapy, requiring at least ONE of the following
 1. NSAID drug therapy

2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority)

1. Physical therapy (teach home exercise/stretching)
2. Manual therapy (chiropractor or massage therapist)
3. Psychological screening that could affect surgical outcome
4. Back school (Fisher, 2004)

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)

Milliman Care Guidelines

Inpatient and Surgical CarE

13th Edition, LOS, Lumbar fusion, 3 days

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)