

US Resolutions Inc.
An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4560
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5 Transforaminal lumbar interbody fusion/decompression L4-L5, inpatient stay 2 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

Peer review, 7/14/09, 07/31/09

Office notes, Dr. 11/25/08, 12/23/08, 01/07/09, 01/21/09, 02/03/09, 06/03/09, 07/02/09

Office note, Dr. 11/26/08

Chiro notes, 12/1/08, 12/3/08, 12/5/08, 12/8/08, 12/10/08, 12/15/08, 12/16/08, 12/17/08, 12/22/08, 12/29/08, 1/5/09, 1/9/09, 1/12/09, 1/14/09, 1/16/09, 1/23/09, 1/26/09, 1/29/09, 1/30/09, 2/2/09, 2/9/09, 2/11/09, 2/16/09

MRI L/S, 12/5/08

Prescription, Dr. 2/20/09

X-ray, Dr. 3/24/09

Psych evaluation, 4/10/09

Office note, Dr. 6/19/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male when he reportedly developed low back pain on xx/xx/xx while using a hand truck to move tires and the truck tipped over. His medical history was positive for diabetes, hypertension, and previous cervical fusion. Examination on 11/25/08 noted decreased lumbar motion with discomfort in all planes. Lumbar x-rays noted increased lumbar angle with multiple spondylitic changes, spondylolisthesis at L5-S1, increased facet joint space L4-5 and decreased joint space from L1 to L3. The impression was facet arthropathy in the lower back and therapy, pain medication, anti-inflammatory medication,

and a muscle relaxant were prescribed. The claimant was not working. The claimant began an extensive course of therapy and chiropractic sessions with no significant change in pain complaints. Lumbar MRI on 12/05/08 revealed narrowing at L2-3 through L5-S1 due to epidural lipomatosis with milder contributions from osteophytes and annular disc bulging, a broad based disc osteophyte L5-S1 superimposed on spondylosis and annular disc bulging and varying degrees of neuroforaminal stenosis bilaterally from L2-3 through L4-5, worse at L3-4 and L4-5. There was central canal and lateral recess bilaterally at T11-T12 with moderate to severe encroachment secondary to central disc osteophyte superimposed on spondylosis and annular disc bulging, the ventral surface of spinal cord was contacted .

The claimant was seen for surgical consult on 03/24/09. Flexion /extension views of the lumbar spine noted minimal spondylosis at L4-5 and a grade I spondylolisthesis L4 to L5 that appeared to reduce slightly in extension, mild ventral spondylosis at L3-4, and minimal ventral spondylosis L2-3. There was slight curvature of the spine convex to the left. Exam findings noted tenderness in the L4-5, L5-S1 paraspinal region with scattered trigger points. Sensation and reflexes were intact in both lower extremities. The impression was spondylolisthesis L4 and L5 and transforaminal lumbar interbody fusion/decompression was recommended. A psychological evaluation on 04/10/09 cleared the claimant for surgery.

The records indicated the claimant underwent gastric bypass surgery and lost forty pounds. His current weight was not documented in the records reviewed. An office visit on 06/03/09 with Dr. noted improvement in back pain following the weight loss. The claimant was not taking any medications, and had been discharged from therapy, and returned to restricted duty. On 06/19/09, Dr. noted no change in the claimant's clinical status with primarily back pain and minimal radiation to the lower extremities. Fusion surgery was recommended due to failed conservative treatment and documented instability.

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

L4-5 translumbar interbody fusion and decompression at L4-5 and two day length of stay is medically indicated and appropriate. These records reflect this is a 56 year old male who had an MRI which demonstrates varying degrees of stenosis, most prominent at L3-4 and L4-5 and epidural lipomatosis at L5-S1. In addition to this, radiographs demonstrate spondylolisthesis with instability at L4-5 and a psychological evaluation 04/10/09, which demonstrates no contraindications for need for surgery. Appropriate conservative care is reasonably documented in physical therapy, medicines, activity modifications. Based upon this documentation, conservative treatment and duration and instability, the surgery is indicated and appropriate. The reviewer finds that medical necessity exists for L4-5 Transforaminal lumbar interbody fusion/decompression L4-L5, inpatient stay 2 days.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 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 discectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Anderson 2000) (Lures, 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

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)