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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 360 L4-S1 3d LOS, 63090, 63091, 22558, 22585, 22851, 20931, 22612

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
Adverse Determination Letters, 7/21/09, 7/2/09
MRI lumbar spine 10/06/05
Lumbar myelogram 07/05/06
CT evaluation of lumbar spine 07/05/06
Dr., office notes 01/12/07
MRI lumbar spine 02/28/07
lumbar myelogram 09/13/07
CT lumbar spine 09/13/07
MRI lumbar spine 07/10/08
Office notes Dr. 12/12/08, 04/16/09
Dr., ortho, peer review 07/02/09

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year-old female with complaints of low back pain. The MRI of the lumbar spine from xx/xx/xx showed small diffuse L4-5 disc herniation that slightly impressed the thecal sac. Small left posterolateral L5-S1 disc herniation contacts the left S1 nerve root and mild facet hypertrophy at L4-5, L5-S1 without mass effect on neural structures was reported. The lumbar myelogram from 07/05/06 showed mild anterior extradural defect at L4-5 disc space

level with mild to moderate narrowing of the L4-5 disc space. On the oblique view, there was a moderate left sided anterior extradural defect at L5-S1 level. No nerve root amputation was reported. The CT of the lumbar spine same day showed at L3-4 disc space asymmetrical bulging of the disc laterally bilaterally causing mild encroachment upon the inferior recess of the right neural foramen and mild to moderate encroachment upon the inferior recess of the left neural foramen. The dural sac and facet joints were maintained. L4-5 disc space revealed mild broad based bulging of the disc causing mild encroachment upon the dural sac and neural foramina. There was thickening of the ligamentum flavus posteriorly.

Degenerative changes are present involving the facet joints. These findings do cause mild spinal canal stenosis at this level. At L5-S1 disc space there was prominent bulging or herniation of the disc noted laterally to the left causing prominent encroaching upon the left lateral aspect of the dural sac and orifice of the left neural foramen. Moderate narrowing of the disc space noted. The right neural foramen and facet joints were maintained. Dr. evaluated the claimant on 01/12/07. Straight leg raise produced spasm on the left at 40 degrees. Dr. felt that the Myelogram and CT and MRI showed herniated lumbar disc at L5-S1 on the left. The MRI of the lumbar spine from 02/28/07 showed mild broad based bulging at L4-5 causing mild encroachment upon the anterior aspect of the dural sac and neural foramina. The facet joints were maintained. L5-S1 disc space had asymmetric bulging of the disc centrally and to the left of midline causing mild to moderate encroachment upon the left neural foramen. The right neural foramen and facet joints were maintained. The 09/13/07 lumbar myelogram showed mild wasting of the contrast column at L5-S1 and mild wasting at L4-5. There was disc space narrowing at L4-5 and L5-S1. No gross evidence of nerve root sleeve amputation with mild irregular contour of the L4 and L5 nerve root sleeves were reported. Vertebral body heights were maintained. The CT of the lumbar spine from 09/13/07 showed multi level degenerative disc disease and spondylosis most notably at L4-5 and L5-S1. The 07/10/08 MRI of the lumbar spine showed multi level lumbar spondylitic changes. L3-4 broad based disc bulge with some ventral flattening of the thecal sac but no significant central spinal stenosis and no focal disc protrusion was reported. It was noted that the disc encroaches on the inferior aspect of the neural foramina bilaterally with resultant bilateral neural foraminal stenosis, a little more prominent on the right. L4-5, broad based disc bulge without focal disc protrusion or significant central spinal stenosis was reported. Disc along the facet and ligamentous disease resulted in prominent bilateral neural foraminal stenosis. Focal increased T2 signal at the posterior margin of the disc consistent with annular tear was present. L5-S1, broad based disc bulge without focal disc protrusion was noted. There was increased T2 signal consistent with annular tear. No significant central spinal stenosis was noted. Disc and osteophyte along with facet disease contributed to the bilateral neural foraminal stenosis which was prominent and appeared a little more severe on the right. Dr. reviewed flexion extension x-rays on 12/12/08 that showed disc space narrowing at L5-S1 and no evidence of instability. Dr. saw the claimant on 04/16/09 for low back pain. The claimant noted that discograms were denied. Dr. recommended 360 fusion at L4-5 and L5-S1.

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

The evidence based guides suggest that surgical fusion should be indicated for individuals who have obvious signs of structural instability and more compelling indication such as progressive neurologic deficit, tumor or infection. In general, a surgical fusion is not supported for individuals with discogenic back pain.

There is no evidence within the records of progressive neurologic deficit, tumor or infection. Furthermore, flexion/extension radiographs do not show evidence of structural instability. Thus, within the records provided there is no compelling case that surgical fusion would be either considered reasonable and/or medically necessary. The above statements are made consistent with the evidence based literature. The reviewer find that medical necessity does not exist for Inpatient 360 L4-S1 3d LOS, 63090, 63091, 22558, 22585, 22851, 20931, 22612.

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,

Milliman Care Guidelines, Inpatient Surgery, 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)