

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior lumbar interbody fusion at L4-5, Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 with two day inpatient stay.

A 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Anterior lumbar interbody fusion at L4-5, Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 with two day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr., 11/10/08

Peer review, Dr., 12/04/08

ODG Guidelines and Treatment Guidelines

MRI lumbar spine, 08/17/07

EMG, Dr., 09/10/07

Pre-surgical assessment, Ph.d., 04/28/08, 09/23/08
Second opinion, Dr., 06/04/08
Lumbar discogram, 06/07/08
Lumbar spine X-rays, 06/09/08
Office note, Dr., 07/02/08, 09/04/08
Lumbar discogram, 08/07/08
Lumbar spine X-rays, 09/18/08
Request for surgery, 11/03/08
H&P, Dr., 11/19/08
Letters of appeal, Dr., 11/24/08, 12/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old diabetic male who was status post laminectomy and discectomy at L4-5 on the left in 2002 for resolution of his symptoms. The electromyography from 09/10/07 showed left subacute L5 radiculopathy, diabetic peripheral polyneuropathy, chronic L5 radiculopathy on the right and bilateral S1 nerve root irritation. On xx/xx/xx, Dr. reviewed the MRI of the lumbar spine from 08/17/07 and felt that it showed surgical changes with evidence of previous lumbar laminectomy and discectomy at L4-5 on the left, now with recurrent disc herniation approximately 7-8 millimeter with severe foraminal stenosis on the left and lateral recess stenosis with associated epidural fibrosis after administration of contrast. There was a disc herniation at L5-S1 paracentrally and toward the left, approximately 4-5 millimeter, with severe left sided foraminal stenosis and lateral recess stenosis. There was decreased disc height and disc desiccation at both L4-5 and L5-S1 with Modic type II changes at both levels and evidence of annular tear at L4-5 on the left and L5-S1 centrally and toward the left, best noted on T2 weighted images. Examination revealed antalgic gait, positive straight leg raise on the left, hypoesthesias at left L5-S1 and 4/5 strength of the left lower extremity. The 2008 lumbar discogram and post discogram CT documented suspect far lateral annular tear at L3-4 level, degenerative nucleogram at L4-5 and L5-S1 levels, spondylosis and multi level degenerative facet hypertrophy. The 09/18/08 lumbar spine x-rays including flexion and extension views showed severe spondylosis, mild retrolisthesis at L4-5 and L5-S1 without visible instability. On 09/23/08, Dr. performed a pre-assessment for surgery and deemed the claimant an excellent candidate for surgery. On 11/19/08, Dr. indicated that the claimant had quit smoking.

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

While this claimant has L4-5 disc pathology with a disc herniation and stenosis, it also appears from the medical records provided that there is significant L5-S1 pathology as well, and it is not clear to this reviewer why only the L4-5 level is being addressed. In addition, there is no documentation in the records that the claimant has maintained cessation of smoking. Dr. stated in the 11/19/08 office note that the claimant had stopped smoking two days prior to the examination.

ODG guidelines document the use of lumbar fusion in patients with instability, infection, tumor, or for revision surgery. While this is a revision surgery procedure of the L4-5 level, that clearly does not answer the question of why L5-S1 is not being addressed. Therefore, the requested surgical intervention is not medically necessary. The reviewer finds that medical necessity does not exist for Anterior lumbar interbody fusion at L4-5, Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 with two day inpatient stay.

Official Disability Guidelines Treatment in Workers' 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 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 Surgery, 12th Edition

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)**