CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: 1/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 revision/decompression/exploration/repair - 2-day length of stay.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Board of Orthopaedic Surgery-Board Certified

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- DC., office visits.
- MD., office visits.
- MD., office visits.
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- DC., office visits.
- MD., office visits.
- MRI of the lumbar spine on 5-8-02, 7-26-02, 4-25-08, 12-12-08
- Surgical interventions on 4-13-04, 7-28-05, 12-12-07
- Spine and Rehab - DC, office visits.
- MD., office visits from 4-10-07 through 12-16-08.
- MD., pain management visits on 11-4-08 and 12-23-08.
- 12-29-08, MD., Utilization Review.
- 1-8-09 MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect a claimant who sustained a work related injury on xx/xx/xx, while lifting.

The claimant sought medical attention and was provided treatment in the form of medications, chiropractic therapy, epidural steroid injections and diagnostic testing.

An MRI of the lumbar spine dated 5-8-02 showed desiccation of disc height at L4 and L5 is indicative of early degenerative disc disease. Spondylotic spondylolisthesis of L5 upon S1 by approximately 10%.

On 7-26-02, an MRI of the lumbar spine showed no evidence of epidural abscess. Mild posterior HNP at L4-L5 and bulge at L5-S1 without spinal canal stenosis or neural foraminal compromise.

On 4-13-04, the claimant underwent L4-L5 and L5-S1 facet fusion. Postoperatively, the claimant continued with low back pain. She underwent postoperative physical therapy.

On 9-1-04, the claimant was noted to have reached statutory MMI and was awarded 20% whole person.

On 7-28-05, the claimant underwent a decompression of the nerve roots with posterior non-segmental instrumentation and repair.

Medical records reflect the claimant continued with low back pain with radiation to the lower extremities. She continued to receive treatment in the form of physical therapy, medications, chiropractic therapy.

On 4-10-07, the claimant came under the care of MD. The evaluator reported the CT scan of the lumbar spine shows post surgical changes and attempted interbody fusion at L4-L5 and L5-S1 with anterior penetration of the pedicle screws. There appears to be no adjacent segment disease of the disc at L3-L4. The evaluator recommended proceeding with surgical intervention.

The claimant was continued on medications. On 8-21-07, the claimant reported she wanted to proceed with surgical intervention. The claimant remained symptomatic with back pain and leg pain. The evaluator reported the claimant will schedule her surgery as time permits. The claimant was continued with therapy under the direction of DC.

On 12-12-07, Dr. performed revision of lumbar spine surgery at L4-L5 bilaterally, L5-S1 bilaterally and L3-L4 bilaterally. Revision of sacral spine surgery, first sacral interval bilaterally with decompression of the cauda equina and S1 nerve roots bilaterally, microdissection technique, harvesting and preparation of bone graft, removal of posterior instrumentation, segmental fixation L4, L5 and S1 bilaterally. Exploration of arthrodesis. Primary repair of pseudoarthrosis L5-S1 bilaterally and primary repair of bone deficit L4-L5, bilaterally.

An MRI of the lumbar spine dated 4-25-08 shows postoperative alignment of the lumbar spine with mild subluxation of L5 on S1. No postoperative arachnoiditis is noted. At L3-L4 an annular disc bugle flattens the thecal sac without foraminal narrowing or canal stenosis. At L4-L5 posterior interbody as well as posterolateral fusion and bilateral laminectomy is seen. No canal stenosis or foraminal narrowing seen. At L5-S1 bilateral laminectomy with posterior interbody as well a posterolateral fusion is seen. Anterior fixation identified. A residual 3 mm left foraminal disc protrusion noted with mild narrowing of the left neuroforamen, facet joint arthrosis is seen. No postoperative canal stenosis.

A follow up visit with Dr. dated 8-12-08 notes the claimant continues to have lower back pain with radiation to her left leg. The claimant is being referred to chronic pain management, as she does not want further surgical intervention. The evaluator noted that x-rays of the hip do not show degenerative joint disease. X-rays of the lumbar spine to include flexion/extension revealed L4-L5 and L5-S1 decompression with global arthrodesis with no motion on flexion and extension views. The evaluator reported the claimant will be seen on as needed basis.

On 11-11-08, the claimant was evaluated by Dr. The claimant reports progressive increasing pain and weakness of her right lower extremity. The evaluator recommended an MRI of the lumbar spine.

The claimant underwent an interventional pain management evaluation. It s noted the claimant has had four spinal surgeries and continues to have failed back surgery syndrome and post-laminectomy syndrome. The evaluator recommended a trial for a spinal cord stimulator.

An MRI of the lumbar spine dated 12-12-08 shows status post fusion L4 to S1. No focal disc protrusion or spinal stenosis.

A follow up visit with Dr. dated 12-16-08 reflects the claimant had a repeat MRI scan of her lumbar spine. This shows previous surgical changes at L4-L5 and L5-S1 with a spondylolisthesis in the recumbent position measuring 5 mm now, which increases when she stands. She also has some recurrent HNP or significant scar tissue in the neuroforamen at L5-S1 on the right. Her leg pain is increasing. She is having a progressive neurological deficit and now has 2/5 weakness of right extensor hallucis longus, 3/5 of tibialis anterior, and 2/5 of extensor digitorum longus. She demonstrates positive sciatic notch tenderness on the right with absent posterior tibial tendon jerks bilaterally. The evaluator reported the claimant has failed lumbar spine syndrome with fracture of previous fusion with pseudoarthrosis at L5-S1 and progressive neurological deficits with spondylolisthesis at L5-S1 with failure of conservative treatment now at 1 year. The evaluator reported that at this point in time because of her progressive neurological deficit in her symptomatology, he felt that further conservative treatment is not warranted. She understands that she will have revision of lumbar spine surgery with exploration at L5-S1, particularly the L5-S1 neuroforamen on the right side to free up the L5-S1 nerve roots on the right, reduction of the spondylolisthesis, and instrumented arthrodesis. She understands that the need for the surgeries because of her progressive neurological deficits and her increase in symptomatology with pain. She is status post anterior cervical discectomy and arthrodesis 3 weeks ago of her cervical spine and she has done excellently from this.

On 12-29-08, MD., performed a Utilization Review. The evaluator reported he could not recommend the proposed surgery as medically indicated and necessary. The evaluator reported there are no flexion/extension views recently to support motion segment instability.

On 1-8-09, MD., performed Utilization Review reconsideration. It was his opinion that the claimant must have all preoperative clinical surgical indications for spinal fusion and all generators should be identified and all physical medicine and manual therapies completed.

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

REVIEW OF THE AVAILABLE MEDICAL RECORDS FINDS ON FLEXION EXTENSION X-RAYS OF 08/12/08 NO MOTION OR INSTABILITY.

DR. NOTES ON A LUMBAR MRI 12/16/08 EVIDENCE OF 5 MM SPONDYLOLISTHESIS AT L5/S1 IN A SUPINE POSITION.

THUS, THERE IS COMPARISON OF AN MRI TO PLAIN X-RAYS AND DRAWING A CONCLUSION OF INSTABILITY WITH PROGRESSION OVER A THREE AND ONE HALF MONTHS. TO DETERMINE INSTABILITY, COMPARISON OF LIKE STUDIES MORE COMMONLY LATERAL FLEXION/EXTENSION FILMS WOULD BE RECOMMENDED. A MYELOGRAM/CAT SCAN WOULD ALSO GIVE SOME INFORMATION ABOUT THE BONE TO ASSESS FOR A NON-UNION OR PSEUDOARTHROSIS.

I WOULD RECOMMEND AGAINST THE RECOMMENDED PROCEDURE DUE TO A LACK OF ADEQUATE DOCUMENTATION AND EVALUATION TO DETERMINE A TRUE INSTABILITY AND PSEUDOARTHROSIS. I WOULD AGREE WITH PRIOR RECOMMENDATIONS AGAINST THE PROPOSED PROCEDURE.

ODG-TWC, last update 12-31-08 Occupational Disorders of the Low Back – Lumbar Fusion:

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion. (Eckman, 2005) This study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) Unilateral instrumentation used for the treatment of degenerative lumbar spondylolisthesis is as effective as bilateral instrumentation. (Fernandez-Fairen, 2007) Patients with degenerative spondylolisthesis and spinal stenosis who undergo standard decompressive laminectomy (with or without fusion) showed substantially greater improvement in pain and function during a period of 2 years than patients treated nonsurgically, according to the recent results from the Spine Patient Outcomes Research Trial (SPORT). (Weinstein-spondylolisthesis, 2007) (Deyo-NEJM, 2007) For degenerative lumbar spondylolisthesis, spinal fusion may lead to a better clinical outcome than decompression alone. No conclusion about the clinical benefit of instrumenting a spinal fusion can be made, but there is moderate evidence

that the use of instrumentation improves the chance of achieving solid fusion. (Martin, 2007) A recent systematic review of randomized trials comparing lumbar fusion surgery to nonsurgical treatment of chronic back pain associated with lumbar disc degeneration, concluded that surgery may be more efficacious than unstructured nonsurgical care but may not be more efficacious than structured cognitive-behavior therapy. Methodological limitations of the randomized trials prevented firm conclusions. (Mirza, 2007)

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 disectomy. [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 crtiteria) & 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- AMERICAN 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)