Becket Systems

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 553-0533
Fax: (207) 470-1075
Email: manager@becketsystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient Stay x 3 days Revision of Posterior Spinal Fusion L5-S1.
(22612,63047,22842,20931,ONEIA)

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:

[X] 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, 6/9/09, 6/25/09
MRI lumbar spine, 04/08/09
New Patient Consultation, Dr., 04/29/09
CT lumbar spine, 05/05/09
Office notes, Dr., 05/06/09, 05/13/09

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a year old male that suffered a work related injury on xx/xx/xx while getting out of a truck. He slipped on a step and landed after twisting his low back on the right side. The claimant had a history of an anterior lumbar spine fusion in 2000. After his work related injury he began to complain of low back pain and right leg pain. A lumbar spine MRI on 04/08/09 revealed at L4-5, a 2-3 millimeter posterocentral discal substance protrusion with the substance only contacting the thecal sac and at L5-S1 there was a left paracentral annular tear and 4-5 mm discal substance protrusion with the substance mildly indenting the thecal sac.

On 04/29/09, the claimant first saw Dr.. At that time he was exhibiting some mechanical back

pain. Dr. recommended that the claimant start some physical therapy, placed him on a Medrol Dosepak as well as Celebrex, Zanaflex and Norco and wanted the claimant to use a neuromuscular stimulator. Dr. ordered a CT scan and told the claimant he could return to light duty.

The claimant had a CT of the Lumbar Spine without contrast on 05/05/09 which showed two metallic cage fusion devices in the L5-S1 disc space incorporated into the adjacent endplates. There was bulge or protrusion seen at L5-S1. There was no central or foraminal stenosis seen in the lumbar spine. A 1 millimeter bulge at L4-5 slightly flattened the thecal sac. There was no lumbar compression fracture or spondylolisthesis. Dr. felt that based on the results of the CT scan and x-ray, the claimant had pseudoarthrosis at L5-S1. Because the claimant had not received any pain relief with conservative methods, Dr. recommended a revision of the claimant's spinal fusion.

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

It appears the claimant had a lumbar spinal fusion in 2000. Dr. feels there is a pseudoarthrosis at L5-S1. There is no documentation of motion segment instability. There is no documentation of progressive neurologic deficit, and the CT scan report does not confirm pseudoarthrosis. Based on this inconsistency, I thus cannot recommend the proposed surgery as medically indicated and necessary at this time. The reviewer finds that medical necessity does not exist for Inpatient Stay x 3 days Revision of Posterior Spinal Fusion L5-S1. (22612,63047,22842,20931,ONEIA).

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates. Low Back

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 diskectomy. [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.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)