

SENT VIA EMAIL OR FAX ON
Jun/17/2009

Applied Resolutions LLC

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DATE OF REVIEW:

Jun/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5, L5/S1 anterior lumbar interbody fusion with posterolateral fusion from L5/S1 and instrumentation with 3-5 days inpatient stay

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

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

OD Guidelines

MRI lumbar 02/19/08

Office notes Dr. 06/26/08, 10/07/08, 10/30/08, 04/10/09, 04/14/09, 05/01/09, 05/26/09, 05/29/09

Psychological consult 08/11/08

Office note Dr. 08/27/08

Letter 11/14/08 by Dr.

MRI lumbar 02/27/09

Letter 04/21/09 Dr.

PATIENT CLINICAL HISTORY SUMMARY

This is a female who reportedly was injured on xx-xx-xx. The records indicated the claimant with back pain and diagnosed with an annular tear L4-5 and L5- S1. A physician visit dated 06/26/08 noted the claimant with ninety percent back pain and ten percent leg pain. Past treatments had included injections and physical therapy with little relief. X-rays showed an annular tear L5- S1 with a small disc space collapse at L4-5. Review of an MRI performed on 02/19/08 showed some disc collapse L4-5 and L5- S1 and also a disc protrusion L5- S1. The claimant was diagnosed with an annular tear L4-5 and L5- S1. Treatment options were discussed. A discogram was recommended for further evaluation.

Physician records in October 2008 revealed the claimant with significant back pain and some

leg pain. The discogram had been denied. Lumbar fusion was discussed. A repeat lumbar MRI done on 02/27/09 revealed a herniated nucleus pulposus L5- S1 and L4-5. Physician records of April and May 2009 noted treatment options were again discussed and a lumbar fusion was recommended.

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

The requested L4-L5 and L5-S1 anterior lumbar interbody fusion with posterolateral fusion at L5-S1 and instrumentation with three to five day inpatient length of stay is not medically necessary based on review of this medical record. This is a woman who has had ongoing back pain since an injury in xx-xxxx. She has had MRI testing documenting disc bulges at L4-L5 and L5-S1, but she has never had any documented structural instability and does not ever appear to have undergone discogram documenting concordant pain. She has also had a 08/11/08 psychologic consultation that documented anxiety, depression, and a pain disorder. ODG guidelines document the use of lumbar fusion in patients with pain greater than six months who have positive instability, have failed appropriate conservative care, and have a passed a psychological evaluation. In this case, this claimant has mild degenerative disc disease without evidence of herniation, progressive neurologic deficit, or structural instability and it would appear that when she saw a psychologic evaluation there was some concern about her condition. Therefore, the requested surgical intervention is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008 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 unilateral neural arch hypoplasia.
- (2) Segmental Instability - 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
- (3) Primary Mechanical Back Pain/Functional Spinal Unit Failure, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability, with and without neurogenic compromise. 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.
- (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

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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.

Milliman Care Guidelines. Inpatient and Surgical Care 13th Edition.

Lumbar fusion: Goal Length of Stay: 3 days postoperative:

Extended Stay: Extensive, multilevel, or combined (anterior and posterior) procedures

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)