



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 3/16/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include an examination under anesthesia with revision lumbar spine surgery, hardware removal, exploration and repair and a two day length of stay.

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

The reviewer is a medical doctor who is board certified in Orthopedic Surgery and has been practicing greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination in its totality.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Healthcare Systems and Dr.

These records consist of the following (duplicate records are only listed from one source): office visit notes by Dr. 1/13/09 to 2/4/09, lumbar CT report of 1/29/09, Healthcare patient follow up notes 6/17/08 to 11/18/08, Healthcare Initial eval note of 4/8/08, Dr. office procedure notes 6/11/08 to 12/22/08 and 6/26/08 RME report by MD.

Dr. 2/20/09 denial letter, 2/10/09 denial letter and a page of surgery codes.

follow up notes from 6/17/08 to 2/10/09, various DWC 73 forms, 7/8/08 to 2/10/09 subjective re-eval forms, therapy and progress notes 7/15/06 to 7/14/08, 7/1/08 to 10/22/08 individual psych notes, psych evaluation of 7/28/08, Dr. office notes of 10/30/08, FCE and intake forms of 6/25/08 (some of the patient forms are marked with 2007 while the witness forms are marked with 2008), 5/20/08 electrodiagnostic testing reports and Dr. office procedure notes 6/2/08 to 12/22/08.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient is a female injured xx/xx/xx while lifting luggage. She underwent L3 to the sacrum fusion and instrumentation then had revision xx months later for instrumentation failure. Approximately xx years later she had an intrathecal morphine pump placed. Currently she complains that her pain has never been adequately relieved and is being recommended for repeat surgery.

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

There is no documentation of progressive neurologic deficit, segmental instability on flexion extension x-rays, psychological screening to determine if patient would be an appropriate candidate for surgery. There has been no identification of pain generators and no CT/myelogram indicating site of pathology has been documented.

The ODG cite the following as 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 xx 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.

**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)