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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Lumbar Laminectomy and Discectomy at Levels L5-S1 with Lateral Transverse Fusion, Pedicle Screw Fixation and Transverse Lumbar Interbody Fusion with C Cage; 1 Day Inpatient Hospital Stay

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr. 01/14/09

Peer review, Dr. 1/23/09

ODG Guidelines and Treatment Guidelines

MRI lumbar spine, 06/14/08

Thoracic spine X-rays, 07/01/08

MRI thoracic spine, 07/09/08

Office notes, Dr. 07/14/08, 07/22/08, 10/01/08

Electromyography, 07/22/08

Compensability assessment, Dr. 07/29/08

Operative report, Dr. 08/22/08, 09/05/08

Impairment rating, Dr. 09/30/08

Office notes, Dr. 11/05/08, 12/23/08

Office note, Dr. 12/23/08

Psychological evaluation, Dr. 02/13/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of low back pain and bilateral leg pain. The MRI of the lumbar spine from 06/14/08 revealed a posterior diffuse bulge at L5-S1 and annular tear, facet joint arthropathy, mild to moderate right and moderate left neural foramina stenosis possibly

affecting the exiting L5 nerve roots. The exiting right L5 nerve root barely abutted the adjacent facet joint and also appeared to inferiorly abut the disc. The electromyography from 07/22/08 showed left L5 radiculopathy. The claimant underwent 08/22/08 and 09/05/08 L4-5 epidural steroid injections for reportedly minimal relief. Dr. evaluated the claimant on 11/05/08. The claimant was taking Vicodin, Flexeril and Amitriptyline. Examination revealed motor, sensory and reflexes were intact.

There was restricted range of motion of the lumbar spine. Diagnosis was predominately low back pain and degenerative disc with annular tear. Dr. recommended disc removal and fusion. Dr. evaluated the claimant on 12/23/08. There were no physical examinations documented. Bending films were recommended for the diagnosis of degenerative disc disease of the lumbar spine. Dr. performed psychological evaluation on 02/13/09 for a lumbar fusion and stated that clearance was given for an implantable device.

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

In general, the evidence-based literature suggests that fusion should be reserved for individuals who have structural instability or compelling indications such as progressive neurologic deficit, tumor or infection. There is no demonstration of this individual having any evidence of structural instability. The records indicate this individual has a degenerative segment at L5-S1 although reportedly EMG has shown radiculopathy at L5. This individual has failed to respond to conservative care in the form of epidural steroid injections.

There is no evidence of progressive neurologic deficit. There is no evidence of structural instability. EMG documents radiculopathy that has not responded well to either temporary or long term conservative measures. This individual reportedly has subjective complaints of bilateral lower extremity pain yet does not have distinct neurocompression at level of L5-S1. The subjective complaints of pain do not correlate with the physical exam findings and/or EMG or imaging.

The patient does not meet the guidelines. There are confounding clinical issues in this case that raise questions as to the etiology of the patients' pain complaints and of what level might be the pain generator. The request for fusion can neither be considered reason and/or medically necessary. The reviewer finds that medical necessity does not exist for 1 Lumbar Laminectomy and Discectomy at Levels L5-S1 with Lateral Transverse Fusion, Pedicle Screw Fixation and Transverse Lumbar Interbody Fusion with C Cage; 1 Day Inpatient Hospital Stay.

Official Disability Guidelines 2009 Updates: Chapter low back: Patient Selection Criteria for Lumbar Spinal Fusion

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Studies conducted in order to compare different surgical techniques have shown success for fusion in carefully selected patients.

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, 13th Edition

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)