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DATE OF REVIEW:

May/18/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

22558, Anterior interbody fusion L4-5; 22585 additional level L5-S1; 67999 retroperitoneal exposure and discectomy times two L4-L5 and L5- S1; 22851 anterior interbody fixation times two L4-L5 and L5-S1; 63047 posterior decompression L4-5; 63048 additional decompression L5-S1; 22612 transverse process fusion L4-L5; 22614 additional transverse L5-S1; 22642, posterior internal fixation L4-S1; 20930 bone graft allograft; 20936 bone graft, autograft in situ; 20938 bone graft, autograft iliac crest; 38220 bone marrow aspirate; L0637Cybertech TLSO; 99221 inpatient hospitalization two to three days.

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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 4/5/09, 4/16/09

Dr. 10/21/04

PA-C/Dr. 01/06/05, 01/17/05, 01/27/05, 02/10/05

Dr. DC 2005

Work Status Report 01/05

Dr. 02/23/05, 03/09/05, 03/10/05, 03/25/05, 04/08/05, 04/27/05

Laboratory 2005

Request for Leave of Absence, undated

Dr. 02/13/09, 02/20/09

Dr. 03/19/09

Request for Surgery 04/02/09

IRO Summary 04/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured on xx-xx-xx. Records showed that he was seen on the day of injury for reported back and left leg pain. X-rays were negative and his neurological examination was intact.

On 02/28/03, x-rays of the lumbar spine were negative. A 01/10/05 MRI of the lumbar spine showed L4-5 desiccation, but normal height. There was an annular bulge and left protrusion indenting the thecal sac. At L5-S1 there was desiccation and a right protrusion that was stable since last MRI but resulted in deflection of the left S1 nerve root, narrowing of the right foramen and there was posterior facet arthrosis. The claimant had an EMG/NCV on 02/22/05 that was read as a possibility of left lumbar radiculopathy. The neurological examination was negative and the claimant was treated conservatively with medication and therapy in 2005.

Records showed that the claimant was seen on 07/11/07 by Dr. for constant back and left leg pain into all the toes and right leg pain to the knee. The claimant was taking Norco, Trazadone and Flexeril. There was a history of smoking. X-rays from 07/05/07 showed retrolisthesis of L5 on S1 and a probable pars defect on the left that was also present in 2005 per Dr. interpretation. The claimant had received four epidural steroid injections over his course of treatment. On examination reflexes were intact. Straight leg raise was positive bilaterally, left more than right. Lasegue's on the left caused back pain. There was left foot eversion and extensor hallucis longus weakness at 3/5. He had left thigh numbness in L2 and 4 and left lower leg numbness in L5 and S1. Dr. recommended a discogram that was not certified.

On 12/17/08 an MRI of the lumbar spine showed that L1-2, 2-3 and 3-4 were normal. There was L4-5 desiccation and a protrusion with borderline canal stenosis. He had an L5-S1 protrusion with mild bilateral neural foraminal narrowing.

The claimant returned to Dr. on 01/14/09. Dr. noted the claimant had not been seen for 11 months due to insurance issues. The claimant reported constant back and left leg pain as well as intermittent right leg pain. There was a small L4-5 herniation with central stenosis and desiccation. At L5-S1 was a herniation to the right with bilateral foraminal stenosis. Medications included Lyrica, Tinazidine and Norco. On examination there was bilateral muscle tenderness. Dorsiflexor strength was reduced to 2/5. There was numbness of the left thigh proximally and distally and tingling of the left knee to the great toe. The claimant had decreased sensation in the dorsum of the right foot and middle toes of the left foot. The impression was L4-5 and L5-S1 pathology and a 360 degree fusion was recommended. A 03/26/09 Psychological Evaluation documented that the claimant was a good surgical candidate.

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

The requested L4-5 and L5-S1 fusion cannot be justified based on the information provided. The most recent MRI of the lumbar spine from 12/17/08 simply indicates desiccation at the L4-5 level. It does not appear the patient has a herniated disc or neural compressive pathology from the L4-5 level. Records do, however, indicate a disc herniation at L5-S1 with bilateral foraminal stenosis. A prior EMG suggested a lumbar radiculopathy and an MRI at one point showed "deflection of the left S1 nerve root". Radiographs from July of 2007 were also noted to show a retrolisthesis at L5 on S1 which would be concerning for instability at that level. Though an L5-S1 fusion may appear justified based on the objective findings noted, the rationale for extending the fusion to the L4-5 level is unclear. Specifically, the claimant does not have instability at the L4-5 level or significant disc pathology at that level.

The records indicate many subjective sensory complaints that cannot be justified based on the MRI. The report of extensor hallucis longus weakness also does not appear consistent with the imaging studies noted. The clinical records do not clarify the inconsistencies. For these reasons the entirety of the surgical procedure cannot be justified based on the information reviewed. Furthermore, the extent of recent conservative care is unknown. The request does not meet the ODG guidelines. The reviewer finds that medical necessity does not exist for 22558, Anterior interbody fusion L4-5; 22585 additional level L5-S1; 67999 retroperitoneal exposure and discectomy times two L4-L5 and L5- S1; 22851 anterior interbody fixation times two L4-L5 and L5-S1; 63047 posterior decompression L4-5; 63048

additional decompression L5-S1; 22612 transverse process fusion L4-L5; 22614 additional transverse L5-S1; 22642, posterior internal fixation L4-S1; 20930 bone graft allograft; 20936 bone graft, autograft in situ; 20938 bone graft, autograft iliac crest; 38220 bone marrow aspirate; L0637Cybertech TLSO; 99221 inpatient hospitalization two to three days.

Official Disability Guidelines Treatment in Worker's Comp 2009 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 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 disectomies on the same disc, fusion may be an option at the time of the third disectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Disectomy.

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-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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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