

Notice of Independent Review Decision

DATE OF REVIEW:

11/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal lumbar interbody fusion L4-5, L5-S1

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

Doctor of Osteopathy, Board Certified Anesthesiologist, Specializing in Pain Management

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The requested transforaminal lumbar interbody fusion L4-5, L5-S1 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 11/17/09 MCMC Referral
- 11/17/09 Notice to Utilization Review Agent of Assignment, DWC
- 11/17/09 Notice to MCMC, LLC of Case Assignment, DWC
- 11/17/09 Request For a Review By An Independent Review Organization
- 11/16/09 letter
- 11/16/09 Confirmation of Receipt of a Request For a Review, DWC
- 11/11/09 Reconsideration/Appeal of Adverse Determination letter,
- 10/28/09, 10/16/09, 10/06/09, 08/31/09, 11/12/08 Chart Notes, M.D.
- 10/27/09 Utilization Review Determination letter
- 01/19/09 Report of Medical Evaluation, DWC
- 01/19/09 Designated Doctor Evaluation, M.D.
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a male with date of injury. The injured individual injured his back lifting and had an L4-S1 laminectomy. He had physical therapy (PT) and is complaining of ongoing back pain. His Independent Medical Exam (IME) noted normal neurological exam with normal deep tendon

reflexes (DTRs), motor, and sensory exam. His surgeon is stating he has radiculopathy but no exam specifics are documented. His MRI showed stenosis with no specific nerve impingement.

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

The injured individual's IME noted no radiculopathy on physical exam (PE) in 01/2009. The requesting attending provider (AP) has not documented specific radicular findings; he just states the injured individual has radiculopathy or hyporeflexia but there is no documentation supporting this statement. Also, there is no psychiatric evaluation to verify the injured individual is a candidate for further surgery. There is mention the injured individual smokes but is "quitting". The MRI showed stenosis but no overt nerve impingement or spinal instability. The injured individual fails to meet Official Disability Guidelines for the requested transforaminal lumbar interbody fusion at L4-5 and L5-S1.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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 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. (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



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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)