



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 4/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an ALIF at L5-S1 and 1 day LOS.

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. This reviewer has been practicing for greater than 15 years.

REVIEW OUTCOME

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an ALIF at L5-S1 and 1 day LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
xxxx and xxxx xxxxxx

These records consist of the following (duplicate records are only listed from one source): Records reviewed from xxxxx: MPAS, PA-C Treatment Memo – 1/20/10; Imaging MRI report – 3/13/09 & 7/6/09; MD Operative Report – 12/21/09; MD Operative Report – 5/5/09; Rebuttal – 2/19/10, Follow-up notes – 12/18/09-2/19/10, New Patient Consult – 10/6/09, Radiology Report – 10/6/09; Ph.D., ABPP COPE letter – 10/21/09.

Records reviewed from xxxxx: Surgical Script – 10/6/09; xxxxx Injured Worker Information/Patient Profile – 9/16/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The 1-19-10 dated Attending Physician records denote a patient (status post hemilaminotomy for HNP at L4-5) with persistent low back pain, right leg radiation, weakness and parasthesias. The 7-6-09 dated MRI revealed scar tissue and degenerative changes without evidence of recurrent HNP. The 5-5-09 dated HNP excision operative summary was reviewed. (The direct back trauma injury mechanism was noted.) A pre-op 3-13-09 dated CT-Myelogram revealed a disc protrusion at L4-5.

The 2-19-10 dated "rebuttal" letter of medical necessity revealed ongoing (despite PT, facet and epidural steroid injections, prior surgery, etc.) "micro- instability" and "discogenic pain" across the post-op segment. Surgical decompression and anterior fusion was felt indicated. The 10-6-09 dated radiologist report of flexion-extension films did not reveal instability. The 10-21-09 dated psychosocial screen was non-problematic.

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

There has been no documentation of recurrent disc herniation or significant instability at the prior decompression site. Therefore, applicable guidelines do not support additional surgical intervention as pain generator(s) have not been definitively established and significant instability has not been evidenced at the segment considered for the major operative intervention of decompression and anterior fusion. The proposed procedure is not medically necessary.

According to the ODG 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).] (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).] (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.

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 & 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)