COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 2/9/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Determine the appropriateness of the previously denied request for L2-5 decompression and fusion with LOS (peer please address number of days for LOS as well) 22612, 22614, 22614, 20937, 63077, 63048, 63048, 63048, 22842.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Texas licensed orthopedic surgeon.

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

x Upheld	(Agree)
□ Overturned	(Disagree)
□ Partially Overturned	(Agree in part/Disagree in part)

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 previously denied request for L2-5 decompression and fusion with LOS (peer please address number of days for LOS as well) 22612, 22614, 22614, 20937, 63077, 63048, 63048, 63048, 22842.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 2/3/10.
- Treatment Recommendation Letter dated 1/11/10.
- Appeal Letter dated 1/8/10, 12/23/09.
- Precert Information dated 12/21/09.
- Texas Workers' Compensation Work Status Report dated 12/8/09.
- Follow-Up Office Visit Report dated 12/8/09, 11/10/09.
- MRI/CT Scan/Injection Request Form dated 11/20/09.
- Physical Therapy Order Form dated 11/10/09.
- Patient Information/Questionnaire Form dated 11/10/09.
- EMG/NCV Examination Report dated 8/4/09.

- Lumbar MRI dated 8/4/09.
- Quickview (unspecified date).
- Surgery Scheduling Form (unspecified date).
- Email Letter (unspecified date).

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):
Gender: M
Date of Injury: xx/xx/xx
Mechanism of Injury: Not provided.
Diagnosis: Lumbar disc herniation, status post prior decompression in 2001.

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

Clinical: This male sustained an injury on xx/xx/xx. The mechanism of injury was not provided. The diagnosis was lumbar disc herniation, status post prior decompression in 2001. The denial letter, dated 12/23/09, noted ongoing back pain with right leg radiation (and a past history of a lumbar decompression in 2001). Right lower extremity motor power was 4/5 on 12/8/09. Dr. indicated, on 12/8/09, that the lumbar MRI, dated November of 2009, revealed significant degenerative spinal curvature with multi-level lumbar retrolisthesis. He also noted that the lumbar MRI, dated December of 2009, showed stenosis at multiple levels and post-laminectomy changes at L2-5. He felt that a revision decompression would further destabilize the lumbar spine. An electromyogram (EMG), dated 8/4/09, had reportedly revealed sacroiliac (S1) radiculitis and right peroneal motor neuropathy. The denial rationale included an unknown psychosocial screen and an unclear rationale as to why the attending physician (AP) was not planning to fuse L5-S1 as part of the proposed multilevel lumbar fusion. A faxed response, dated 1/24/10, from Dr.'s office, noted that the rationale for the non-consideration of L5-S1 fusion was that the claimant was asymptomatic at that area. A reconsideration request (denial letter), dated 1/8/10, was reviewed. His prior treatment included only 2 days (much less than prior injections) of 100% relief with an epidural steroid injection (ESI). The claimant's 2001 procedures included laminectomies and decompressions at L2-3 and L4-5. The X-rays recently revealed stenosis and retrolisthesis at L2-3, disc protrusion and retrolisthesis at L3-4, spondylosis, disc protrusion and laminectomy defect at L4-5. There was "no evidence of instability" on flexion-extension films. The lack of a psychosocial screen and the non-surgical approach at the L5-S1 area that had been electro-diagnostically positive were also noted as the rationale for denial.

The AP's, Dr., records were then reviewed in their entirety. This included a letter from Dr., dated 1/11/10. He noted that the pain-relieving ESI had proved that the L4-5 level was a pain generator and that there was no S1 nerve root impingement on the imaging studies or clinically on the exam. The fusion rationale was that of the multi-level 23 degree coronal plane deformity with symptomatic multi level spondylolisthesis on the sagittal plane. He felt that there was literature supporting that the deformity will progress and/or the outcomes will be "worse" with decompression alone. Prior Dr. notes, including those from 12/8/09, documented symptomatic "lumbar stenosis" and "neurogenic claudication." The right gastroc-soleus muscle had 4/5 motor power as did the quadriceps, extensor hallucis longus (EHL) and tibialis anterior.

Rationale: The claimant has not had a psychosocial screen opinion documented. He has not had evidence of instability documented via extension-flexion films. He has not had evidence of severe intradiscal pathology documented either. All of the preceding are criteria for a fusion. Although the AP concerns were noted with regards to the possibility of fusion progression, this concern is not a definitive eventuality or a criterion within the ODG and could be potentially treated with fusion if it occurs later on post decompression procedure alone. In addition, the AP documented pain relief with an injection at one level and it was unclear if the pain generators were coming from all of the levels considered for decompression and fusion, especially when the pain relief only lasted two days, at most. Also, he had weakness of the gastroc-soleus muscle of the symptomatic leg that correlated with the EMG findings and it would appear that a decompression at that L5-S1 radicular level would be in order. Therefore, with a lack of full clarity of exactly which levels were pain generating, which levels were unstable (if any) and a potential lack of treatment at a documented area productive of weakness and EMG findings, (along with a lack of psychosocial screening), the proposed aggregate of procedures did not appear to be reasonably required medically, at this time., as per applicable guidelines including the ODG which state, "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. 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)."

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

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

x ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Low Back, Criteria for Lumbar Fusion.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).