

SENT VIA EMAIL OR FAX ON
Feb/09/2010

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient lumbar surgery to include examination under anesthesia, lumbar laminectomy, discectomy at L4-5-S1; arthrodosis with cages, posterior instrumentation at L5-S1

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 1/13/10 and 1/20/10

Dr. 4/28/09 thru 6/23/09

Electro-Diagnostic Interpretation 11/30/09

Electrodiagnostic Results 11/20/09

Pre-surgical Screening 7/23/09

Dr. 2/24/09 thru 12/1/09

MR Spine 12/13/08

Clinic 8/28/08 thru 3/18/09

PT Eval 11/19/08 thru 12/1/08

Treatment 8/29/09 thru 10/03/2009

Dr. 10/6/09

DDE 11/18/09

Dr. clinic note 02/23/2009

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was lifting a heavy bag of trash. He complains of back pain radiating into both legs, left greater than right. He has had physical

therapy, chiropractic therapy, massage, and pain medications. On examination there is a decreased knee jerk on the left with parasthesias in the L4 and L5 nerve root distribution on the left. A psychological evaluation 07/17/2009 recommended he participate in individual psychotherapy pre and post-surgery to address pre-surgery worries and clarify surgical expectations and any additional psychological problems with pain symptoms. It appears he did undergo these preoperative sessions. An MRI of the lumbar spine 12/13/2008 showed L4-L5 broad-based disc protrusion with neural impingement of the anterior thecal sac and exiting L4 traversing L5 nerve roots. No mention is made of the L5-S1 level. The provider states that the plain films of the lumbar spine show at L5-S1 bone-on-bone spondylosis and stenosis with facet subluxation and foraminal stenosis. He concludes that there is instability there. However, these radiograph reports are not submitted for review. Electrodiagnostic studies 11/30/2009 reveal evidence of acute left L4-L5 radiculopathy and bilateral plantar neuropathy, of uncertain etiology. The provider is requesting inpatient lumbar surgery, to include examination under anesthesia, lumbar laminectomy, discectomy at L4-S1, arthrodesis with cages, posterior instrumentation at L5-S1.

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

The proposed surgery is not medically necessary. It is unclear why L5-S1 needs to be fused. No plain x-rays of the lumbar spine reports were submitted for review. The MRI of the lumbar spine report does not note any abnormality at L5-S1. Therefore, based on the submitted documentation, the procedure, as a whole, is not medically necessary.

References/Guidelines

2010 *Official Disability Guidelines*, 15th edition

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 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-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)