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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/21/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical necessity for L5-S1 discectomy and fusion with two day stay using 22325,22558,22840,22851,20938,22612,63030,63035,69990 and 22899.

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

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back

Office note, Dr. 09/10/09, 09/30/09

Review, Dr. 10/19/09

Office notes, Dr. 10/20/09, 06/01/10

Clinical Interview Psychology Evaluation, 11/04/09

Lower EMG/NCV Report, 11/23/09

Peer review, Dr. 06/14/10

Peer review, Dr. 06/23/10

6/15/10, 6/23/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his low back on xx/xx/xxxx and felt a sudden onset of burning pain in his low back. The claimant was initially treated with Hycodone, Flexeril and Lyrica. The claimant had an epidural steroid injection on 09/24/10 without relief from his symptoms. On 10/19/09, Dr reviewed the MRI of the claimant's lumbar spine (no date given) and noted that it revealed a non contained disc herniation rated as stage III with annular herniation, nuclear extrusion, disc desiccation and spinal stenosis at L5-S1. The claimant saw Dr. on 10/20/09 and complained of back pain and bilateral leg pain. His back pain was worse than his leg pain and he described the leg pain as equal although

sometimes it was worse on the right. On physical examination, the claimant had a positive Spring test, positive Flip test bilaterally, positive Lasegue's bilaterally at 45 degrees, positive Bragard's bilaterally, absent posterior tibial tendon jerks bilaterally, increased ankle jerks bilaterally, paresthesias in L5 and S1 nerve root distribution bilaterally and weakness of gastroc-soleus on the right. A psychological evaluation on 11/04/09 indicated that the claimant was considered to be a fair to good risk for the surgical procedure. The claimant underwent electrodiagnostic testing on 11/23/09 that revealed bilateral L5 and S1 irritability. When the claimant saw Dr. on 06/01/10, his physical examination was basically unchanged except for a notation by Dr that stated the claimant's pain symptoms and weakness were worsening and he now had numbness and tingling bilaterally. X-rays of the claimant's lumbar spine that included flexion/extension views revealed L5-S1 near bone-on-bone spondylosis and stenosis with facet subluxation and foraminal stenosis, retrolisthesis at 8 mm in extension. A Peer Review on 06/14/10 denied Dr. request for surgery because there had been no documentation of therapy and no submitted documentation of imaging studies by an independent radiologist at the proposed level. There also had been no submitted documentation of segmental instability. Another Peer Review on 06/23/10 denied Dr. appeal because there was no documentation of six months of tried and failed conservative therapy as required by Official Disability Guidelines. The reviewer stated that the records received did not provide objective imaging evidence of instability that Dr. had stated in his physical examination report.

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

The patient has had epidural steroid injection, Flexeril, Lyrica with both back and radicular symptomatology. Instability is documented on radiographs. A psychological evaluation on 11/04/09 indicated that the claimant was considered to be a fair to good risk for the surgical procedure. Based upon these findings, the patient meets the ODG guideline for discectomy and fusion. The reviewer finds that medical necessity does exist for Medical necessity for L5-S1 discectomy and fusion with two day stay using 22325, 22558, 22840, 22851, 20938, 22612, 63030, 63035, 69990 and 22899.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back

Lumbar fusion:

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined below. After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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.

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion

Discectomy/laminectomy -

Required symptoms/findings; imaging studies; & conservative treatments below

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present and should correlate with symptoms and imaging

C. L5 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
2. Mild-to-moderate foot/toe/dorsiflexor weakness
3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following

1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.

II. Imaging Studies corresponding to radicular findings and physical exam findings

A. Nerve root compression, Lateral disc rupture, Lateral recess stenosis

III. Conservative Treatments, requiring ALL of the following

A. Activity modification,

B. Drug therapy, requiring at least ONE of the following

1. NSAID drug therapy
2. Other analgesic therapy
3. Muscle relaxants
4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority)

1. Physical therapy (teach home exercise/stretching
2. Manual therapy (chiropractor or massage therapist

3. Psychological screening that could affect surgical outcome

4. Back school

Milliman Care Guidelines® Inpatient and Surgical Care 14th Edition

22558: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar, goal length of stay is 3 days

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)