



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a minimally invasive posterior lumbar fusion at L4-S1.

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. The reviewer has been in practice for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a minimally invasive posterior lumbar fusion at L4-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: LHL009 – 4/15/10; Grievance/Appeal Request – 3/23/10, Denial Letters – 3/30/10 & 4/9/10, Certificate of Coverage; Denial Letter w/ Peer to Peer notes – 3/5/10; Guidelines for Lumbar Fusion; Pre-Auth Request – 3/5/10; Patient Info – 3/1/10; MD notes – 1/29/10-3/4/10; Radiology Assoc. MRI report – 5/27/08 & 3/10/10 and X-ray report – 3/10/10; AMR Peer Review Report – 3/29/10; Pain Care Progress Notes – 4/21/09-8/11/09, Radiofrequency Thermocoagulation of Medial

Branch Nerve report, Post Procedure Call Back note, Disclosure, Discharge Notes, and Physician's Orders – 6/2/09; Laboratories report – 4/9/09; Pain Assoc Notes – 12/11/08-2/25/09, Procedure Reports – 12/29/08-2/9/09; Diagnostics Lab Report – 2/15/08; A. Josh Update Note – 3/24/10; Review Report – 4/8/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant letter was reviewed, entitled “Peer to Peer” document. The guidelines were reviewed as provided. The 1/29/10 (and thereafter) dated Attending Physician records discussed low back pain with left leg radiation and parasthesias in an S1 distribution, along with subjective left foot (“subtle”) weakness. The neuro exam was unremarkable except for a decreased left Achilles reflex. The MRI showed degenerative disc pathology, especially at L4-5 and L5-S1 with nerve root contact at the later. The claimant was noted to have failed significant no-operative treatment. The 5/27/08 and 3/10/10 dated MRI's revealed the above findings as was noted per the Attending Physician (although the L5-S1 disc was noted to be smaller). The 3/23/10 dated denial letter noted rationale that there was not evidence of instability on flexion-extension films.

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

Without documented evidence of instability (on flexion-extension films) and/or a psychosocial screen, a procedure incorporating lumbar fusion would not be reasonably required as per applicable guidelines.

ODG: 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 (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.

ACOEM: p211 re Spinal fusion

3. Recommendation: Lumbar Fusion for Radiculopathy from Disc Herniation

Lumbar fusion is not recommended as a treatment for patients with radiculopathy from disc

herniation or for patients with chronic LBP after lumbar discectomy.

Strength of Evidence – Not Recommended

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)**