Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 3/8/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The services under review include a lumbar revision surgery, hardware removal, exploration and repair at L4/L5/S1 with two 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a lumbar revision surgery, hardware removal, exploration and repair at L4/L5/S1 with two day LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Dr.
Dr. and Dr..

These records consist of the following (duplicate records are only listed from one source): : 1/19/10 denial letter, office visit notes by Dr. 1/11/10 to 1/12/10, 10/27/09 to 11/4/09 SOAP notes Spine and Rehab (SASR), 9/14/09 lumbar MRI report, 5/24/07 electrodiagnostic report, 5/24/07 Chiro history report and notes, 11/22/06 lumbar MRI report and 1/25/10 denial letter.

Dr.: all records provided were provided in the records.

Dr. : office notes by Dr. 10/16/09 through 1/28/10.

Dr.: SOAP & exam notes 3/19/07 to 10/26/09 Spine Rehab (SASR), various DWC 73 forms, 10/22/07 operative report, 11/13/08 report by Orthopaedic Institute, 9/18/08 xray report, 9/6/08 CT scan, 3/7/07 to 6/11/08 report by MD, 5/11/07 report by MD and 3/1/07 report by MD.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant's history was documented in the 1 22 10 dated denial letter, with rationale that the 9 14 09 dated MRI didn't reveal an indication for additional decompression. The 1 29 10 dated denial letter revealed rationale that peer-to-peers were attempted. The hardware was felt to be "stable" and the anterior placement that was reportedly irritating the sympathetic nerve chain was not reflected by any abnormal neurological exam. The prior fusion was noted to be solid also. The 1 11 10 dated note from a Dr. indicated that his review of the 9 14 09 enhanced MRI revealed residual stenosis and anterior screw penetration "at the sympathetic chain." The note from 1 12 10 revealed that the had an antalgic gait, back and leg pain with evidence of prior fusion (attempt). The screws were felt to have been "irritating the anterior cortex and the claimant was noted to have undergone a prior "laminotomy instead of laminectomy." On exam, a positive straight leg raise, only absent posterior tibialis reflexes with "stocking glove" sensation and a normal motor exam. The claimant had previously been referred for pain management and was on significant medications for pain reduction. She continues to be highly symptomatic as per the AP notes. The claimant was felt to have a failed spine surgery syndrome with misplaced hardware and sympathetic chain irritation along with the proposed surgical indication. Prior records from Spine and Rehab. (signed by the claimant) from 11 4 09 and prior denoted that a (5 24 07) electrodiagnostic had revealed S1 radiculopathy with "polyneuropathy") and that the imaging studies had not revealed stenosis and did reveal a prior laminectomy. A 9 14 09 dated imaging study revealed that the hardware and graft were "anatomically positioned" and that there was no evidence of canal stenosis and only mild foraminal narrowing. The 1 28 10 and prior dated pain management notes were reviewed with medications noted. On 12 31 09 the claimant noted that "during the day she does fine." Exam findings revealed numerous soft tissue areas of tenderness, positive facet-mediated pain and 5/5 motor power. The patient had been noted to have been "basically satisfied with her current analgesic regime." On 10 16 09, the notes revealed that the prior emg/ncv had only revealed possible S1 radiculopathy (plus polyneuropathy), was incompatible with the normal physical exam and that the pain is clinically "originating on the facet joints" and "sacro-iliac joints."

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

The applicable ODG's support that decompression is only indicated with objective neurologic findings that must exist on physical examination, in addition to subjective complaints. The claimant's subjective symptoms and response to the non-operative treatment has been highly variable. The "stocking-glove" and/or normal sensation (along with normal knee and ankle reflexes and motor exam) point away from nerve root impingement and potentially toward the electrodiagnostically-associated polyradiculopathy and/or other pain generators such as SI or facet joints. In addition, there has been no evidence of flexion-extension films documenting spinal instability. In addition, the AP's read of the imaging studies appears to be the opposite of the radiologist who suggests no significant abnormality of stenosis or abnormal hardware position. Therefore, neither additional decompression, hardware removal nor posterior fusion would appear to be reasonably required at this time.

Reference: ODG Indications for Surgery -- 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. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:
    1. Severe unilateral quadriceps weakness/mild atrophy
    2. Mild-to-moderate unilateral quadriceps weakness
    3. Unilateral hip/thigh/knee pain
B. L4 nerve root compression, requiring ONE of the following:
    1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
    2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
    3. Unilateral hip/thigh/knee/medial pain
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

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.

ACOEM GUIDELINES-Chronic Pain Chapter

SUMMARY OF MANAGEMENT OF CHRONIC PAIN CONDITIONS

The following is a short outline followed by summaries of each specific disorder that is addressed in this guideline.

 Identify remediable generators of nociception or neuropathy.

 When there is no *readily resolvable* pain generator, the focus should be on functional restoration. Treatments should be individualized, taking into account co-morbidities and preferences.

 Address co-morbid mental health conditions with appropriate behavioral modification or medications.

 Medications or other treatments that have not been of clear benefit with an adequate trial should be discontinued prior to or immediately after the addition of alternative options. Treatments that are of some benefit should be continued while alternatives are weighed and checked to attain a reasonable chronic pain modulation (as a partial control is better than none in this population) to prevent them from seeking potentially detrimental treatment schemes. Medication

effectiveness and adverse effects should be reviewed regularly with the patient and well documented in the medical record.

 Interventions with the potential for serious adverse effects should be employed if pain reduction and functional improvement will reasonably outweigh potential harms to the patient. Such interventions should be preceded by an adequate trial of conservative care. There are times, however when judicious interventional or medication therapy may be more appropriate than other strategies with potential to reduce pain and overall costs. Treatment of most chronic pain conditions consists of a combination of therapies and interventions. Physical and psychosocial aspects should be considered when developing a treatment plan to suit the patient's needs, reduce their pain, and improve their function. Most importantly, the patient must actively participate in the treatment plan. This often requires significant patient educational efforts. Guidance is available to assist with this approach.

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)**