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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Decompression L4-5 With Posterior Lumbar Interbody Fusion and Instrumentation

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

MD, Board Certified Neurosurgeon

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

Adverse Determination Letters, 4/1/10, 4/9/10

xxxxxxx, 4/13/10, 2/28/10

Note, 3/29/10

Medication List, 6/20/08

xxxxxxx, MD, 4/2/10

Clinic Note, 2/26/10

MRI Lumbar Spine w/o Contrast, 3/16/10

Surgery Scheduling Form (undated)

Letter to Patient, 2/26/10

Spine Lumbar 4 Views, 6/21/07

MRI Lumbar Spine w/wo contrast, 9/15/05

ODG Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured in xxxx. He has had 3 prior surgeries at the L4-L5 level. He has undergone medications as well as epidural steroid injections. He complains of right leg pain, foot drop and numbness in the right L5 distribution. His examination reveals a positive straight-leg raising on the right and weakness in right dorsiflexion. Plain films of the lumbar spine 06/21/2007 reveal moderate narrowing of the L4-L5 disc space with no obvious instability on flexion and extension. A lumbar MRI without contrast on 03/16/2010 reveals further disc-space collapse at L4-L5 with Modic end-plate changes. There is persistent

dorsal low signal in the right paramedian and foraminal location, some subligamentous cephalad extension, which could represent disc versus granulation tissue. There is reduced epidural fat in the right lateral recess (moderate stenosis). An MRI of the lumbar spine 05/04/2007 with and without contrast showed interval development of a large right-sided disc herniation at L4-L5. Apparently, surgery was cancelled due to elevated HbA1C levels. The provider felt that a re-do decompression at this level would involve a partial, if not full facetectomy, resulting in an iatrogenic instability, necessitating a fusion.

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

Decompression L4-5 With Posterior Lumbar Interbody Fusion and Instrumentation is not medically necessary, based on the submitted documentation. While the claimant may be a surgical candidate, there is insufficient information to support the medical necessity of this procedure. It is stated that surgery was cancelled three years ago, and there was a MRI that clearly showed a re-herniation of a lumbar disc at L4-L5 on 05/04/2007. Dates of the prior three lumbar surgeries are unknown. Furthermore the most recent MRI is not performed with contrast, and it is therefore, no known whether there truly is, presently, recurrent disc versus scar tissue. Lastly, although prior epidural steroids are mentioned, it is unclear whether the claimant has undergone any recent conservative measures. It is also not known if his physical examination findings are stable or are new. Based on all of these reasons, the reviewer finds that medical necessity does not exist at this time for Decompression L4-5 With Posterior Lumbar Interbody Fusion and Instrumentation.

References/Guidelines

ODG "Low Back" chapter

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 - Spondylytic 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 disectomy. [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 disectomies on the same disc, fusion may be an option at the time of the third disectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Disectomy.

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)