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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient LOS 1 ALIF L5-S1 63090 22558 22851 20931 95920x 2

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

OD Guidelines

MRIs lumbar spine: 09/04/09, 05/06/10

Dr.: 06/08/10, 07/15/10, 09/27/10

Dr.: 06/29/10

Dr. Pre Surgical Evaluation: 07/21/10

Peer Review: 09/24/10, 10/04/10

09/24/10, 10/04/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who sustained a work related injury to his low back on xx/xx/xx when he was involved in a motor vehicle accident. The claimant was stopped at a yield sign when he was rear-ended by another vehicle. He drove himself to the emergency room where x-rays were taken and he was diagnosed with a lumbar strain. The claimant was treated conservatively with physical therapy, chiropractic adjustments, a TENS unit, stretching, topical analgesics and injections without benefit. An MRI of his lumbar spine on 05/06/10 revealed degenerative disc disease and loss of disc height. There was a posterior disc bulge present at L5-S1 narrowing the neuroforamina mildly without evidence for contact with the exiting nerve root. X-rays (AP, lateral, flexion/extension) done in Dr. office on 06/29/10

showed a decrease in lordosis on the lateral view and disk space narrowing at the L5-S1 level. There were no fractures or instability pedicles visualized. On examination the claimant had a positive straight leg raise on the left that produced left buttock and leg pain. He had 4/5 strength testing with the extensor hallucis longus and dorsiflexion on the left side. His strength was 5/5 with plantar flexion, but sensation was decreased in the L5 dermatome on the left.

A psychological evaluation on 07/21/10 found no contraindication for surgery. Dr. recommended fusion at L5-S1 since the claimant had failed conservative treatment and had been experiencing pain since 2009. This was denied in two peer reviews dated 09/24/10 and 10/04/10 because there was no documentation of instability.

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

The evidence based ODG Guidelines discuss the indications for discectomy and laminectomy. They include symptoms or findings which confirm the presence of radiculopathy including objective findings on examination. They discuss the findings for specific nerve root compression. They also note the imaging studies should be in concordance with radicular findings on radiological evaluation and physical examination findings. Lastly conservative treatments should have been exhausted to include activity modification for greater than two months, drug therapy and some type of therapy whether it is therapy or manual therapy. The indications for spine fusion for chronic low back pain should not be considered within the first six months except for cases of fracture, dislocation or progressive neurologic deficit. The indications for spine fusion include spondylolisthesis, i.e. neurologic defect, segmental instability, and primary mechanical back complaints with segmental failure with progressive degenerative changes. They also include surgery for failed previous operations. In cases where surgery is a consideration, all pain generators should be identified, all physical medicine and manual therapy intervention completed. The X-rays should demonstrate spinal instability as noted. There should be spinal pathology limited to only two levels and a psychosocial screen with confounding issues should be addressed. Also individuals are asked to refrain from smoking for six weeks.

There are no indications for spinal fusion in this particular case. There is no evidence of structural instability, no evidence of progressive neurologic deficit. Furthermore the chief complaint is back pain and only intermittent pain of left leg pain. The Official Disability Guidelines have not been satisfied. The reviewer finds that medical necessity does not exist for Inpatient LOS 1 ALIF L5-S1 63090 22558 22851 20931 95920x 2.

Official Disability Guidelines Treatment in Worker's Comp, 15th edition, 2010 Updates. Low Back -- 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. (Andersson, 2000) 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

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

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following

1. MR imaging
2. CT scanning
3. Myelography
4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following

- A. Activity modification (not bed rest) after patient education (\geq 2 months)
- 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 (Fisher, 2004)

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)

Milliman Care Guidelines® Inpatient and Surgical Care 14th Edition: goal LOS is 3 days for anterior lumbar spinal fusion

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)