



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/12/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of inpatient surgical room, major bone graft, intra-operative neurophysiology testing, neuromuscular junction testing, lumbar laminectomy, addition segment, post instrum w/o segmt fixa, major bone graft, vertebral corpectomy, posterior lumbar fusion, arthrodesis-ant interbody tech, application of prosthetic device, and bone marrow aspiration only (RC111, 20902, 95920, 95937, 63047, 63048, 22840, 20902, 63090, 22612, 22558, 22851, 38220).

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 10 years in this field.

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 prospective medical necessity of inpatient surgical room, major bone graft, intraoperative neurophysiology testing, neuromuscular junction testing, lumbar laminectomy, addition segment, post instrum w/o segmt fixa, major bone graft, vertebral corpectomy, posterior lumbar fusion, arthrodesis-ant interbody tech, application of prosthetic device, and bone marrow aspiration only (RC111, 20902, 95920, 95937, 63047, 63048, 22840, 20902, 63090, 22612, 22558, 22851, 38220).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Organization

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Denial letter – 3/9/10, 6/21/10, 8/31/10, & 9/9/10; MD Office Note – 12/11/07-7/21/10, Script – 3/1/10, 5/19/10, & 7/21/10, New Patient Info – 3/1/10, Records release consent & Medication Guidelines– 12/7/07 & 3/1/10; Ph.D., LPC Pre-surgical Behavioral Health Eval – 8/12/10; MD Office Notes – 1/7/10, Lumbar MRI – 11/14/07, Referral Script - undated; MD CT Lumbar Spine & Lumbar Myelogram – 3/29/10; TX-AN Anesthesia Procedure Report – 2/28/08; DC Office Note – 1/16/08; MD Physical Exam report – 5/29/09; Medical Evaluation – 11/2/07;. Medical Referrals – 11/12/07, and Patient Info Forms – 11/7/07.

Records reviewed from Organization: Pre-auth Request – 8/25/10, Reconsideration Request – 9/1/10, and Letter of Reconsideration – 8/31/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant has had back pain with spondylolysis and grade 1 spondylolisthesis at L5-S1. Grade 4/5 right gastrocnemius muscle strength and hypoesthesia in the S1 distribution was noted on 5/19/10. On 7/21/10, the claimant had ongoing low back pain with radiation. An 11/4/07 dated MRI revealed no evidence of bulge or herniation at L5-S1. Facet arthropathy and mild nerve impingement had been noted on a CT-myelogram on 3/29/10. 3/29/10 dated flexion-extension films did not reveal subluxation or angular deformity. The claimant had been treated with medication, ESIs, and physical therapy without significant improvement. Previously on 5/29/09, the neuro exam of the lower extremities had been noted to be normal.

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

Clinical and imaging studies have not consistently documented nerve root impingement with disc herniation (or even protrusion.) Flexion-extension films have not documented radiographic evidence of segmental instability. Therefore, the aggregate of the proposed procedures of decompression and fusion are not medically necessary as per applicable ODG clinical guidelines.

ODG: 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.

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)