

SENT VIA EMAIL OR FAX ON
Sep/24/2010

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3/4 Decompression D-c Hardware L3/4 TLIF 3-Day Inpatient Stay and LSO Brace and bone growth stimulator

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

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)

LSO Brace is medically necessary

Bone Growth Stimulator is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr. 06/22/99, 02/27/01, 05/07/02, 04/08/03, 05/21/04, 8/16/06, 10/17/06, 10/31/06, 11/28/06, 12/27/06, 03/21/07, 09/11/07, 10/23/07, 11/06/07, 04/03/08, 07/21/09, 01/13/10, 07/13/07

Operative report, Dr., 07/24/00

CT lumbar spine, 10/31/06

Operative report, Dr., 10/04/07

CT lumbar spine, 11/06/07

PT note, 12/07/09

CT lumbar spine, 07/13/10

Office note, Dr., 07/26/10

Peer review, Dr., 08/05/10

Office note, Dr., 08/17/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was status post L4 to sacrum fusion. The claimant has treated postoperatively with sacroiliac joint injections, facet joint injections, physical therapy, medication, and work restrictions. On 07/21/09, Dr. documented that the lumbar spine x-rays showed L3-4 instability and moderate L3-4 stenosis. The CT of the lumbar spine, dated 07/13/10 showed stable appearance of fusion L4-S1. There was moderately severe stable central canal stenosis and bilateral neural foraminal stenosis at L3-4 due to disc bulge and ligamentous and facet hypertrophy. There was mild disc bulge and facet hypertrophy at L2-3 and was unchanged. New osteophyte formation at the posterior inferior L1 endplates with asymmetric soft tissue attenuation at the disc space and superior to the disc space centrally and the left of midline which may represent extruded disc material was reported. Superior to the disc space this crowded the ventral left aspect of the thecal sac along expected course of left L1 and L2 nerves. The psychologist cleared the claimant for surgery on 07/26/10. The claimant complains of low back left leg pain. There were no recent exam findings in the records reviewed.

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

The L3-4 decompression and transforaminal lumbar interbody fusion is medically indicated and appropriate in this male who underwent L4 through sacral fusion. This has gone on to fuse but has developed a transitional segment, which most recently on CT scan demonstrated severe stenosis in 2007, as well as segmental instability at L3 and L4. This then was further corroborated on a 07/13/10 CT scan. A psychologist notes no contraindication to surgery. There is instability at this level as well as appropriate conservative treatment. Therefore, the surgery including the three-day length of stay as proposed is reasonable and appropriate based on the ODG Guidelines as well.

The proposed lumbosacral orthosis (LSO) back brace would be considered medically necessary and appropriate based upon the review of the records in this case.

Official Disability Guidelines state that there is conflicting evidence regarding use of these braces and case-by-case recommendations are necessary.

This claimant is status post fusion from L4 to the sacrum in the past. Fusion is planned at L3-4. As this represents a significant stress riser from a fused segment to a non-fused segment, use of a back brace would be reasonable. Therefore, based upon the Official Disability Guidelines in this case, an lumbosacral orthosis (LSO) back brace, preferably off the shelf would be considered medically necessary and appropriate in this case.

A bone growth stimulator would not be considered medically necessary or appropriate in this case.

If one looks at the Official Disability Guidelines, criteria for the use of invasive or noninvasive electrical bone growth stimulators, these may be considered medically necessary as an adjunct to spinal fusion surgery patients for patients with any of the following risk factors for failed fusion: 1) one or more previous failed spinal fusion surgery, 2) grade 3 or worse spondylolisthesis, 3) fusion to be performed at more than one level, 4) current smoking habit, 5) diabetes, renal disease, or alcoholism.

In this case, there is no history of failed spinal fusion surgery. There is no spondylolisthesis greater than grade 3. Based upon review of the notes provided, fusion is to be performed at only one level. There is no current smoking habit, a history of diabetes, renal disease, or alcoholism based upon the notes provided.

Therefore, based upon the Official Disability Guidelines, a bone growth stimulator would not be considered medically necessary or appropriate in this case.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back, lumbar fusion

Lumbar fusion- **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 Surgery, 14th Edition

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)