

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 9/7/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

63047: Removal of spinal lamina. Long Descriptor: Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

22630: Lumbar spine fusion. Long Descriptor: Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

22612: Lumbar spine fusion

Long Descriptor: Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

22840: Insert spine fixation device. Long Descriptor: Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

20931: Sp bone algrft struct add-on. Long Descriptor: Allograft for spine surgery only; structural (List separately in addition to code for primary procedure)

20936: Sp bone agrft local add-on. Long Descriptor: Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or lamina fragments) obtained from same incision (List separately in addition to code for primary procedure)

77003: Fluoroguide for spine inject. Long Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

QUALIFICATIONS OF THE REVIEWER:

Neurosurgery, Surgery Spine

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)

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to air analyses by, dated 8/18/2010
2. Confirmation of receipt dated 8/18/2010
3. Request for a review dated 8/17/2010
4. Letter by MD, dated 8/16/2010
5. Notification of determination by MD, dated 8/6/2010
6. IRO request form dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female, who sustained injury on xx/xx/xx. The injured employee has complaints of tenderness and pain in the lumbar spine. MRI lumbar spine performed on 03/11/2010, demonstrates decreased degenerative signal in the disc at L4-5 and L5-S1. Canal stenosis is noted at L4-5 with lateral recess stenosis noted bilaterally. There appears to be a small central annular tear at the L4-5 level. At L5-S1, spondylosis was present and mild canal foraminal stenosis is noted. It appears that the injured employee has been pregnant and care was delayed due to childbirth. Initial physical therapy exam performed on 04/12/2010 revealed evidence of a decreased sensation in the L5 dermatome in the left lower extremity. The patient did have epidural steroid injections on 05/13/2010, and follow-up on 06/15/2010, reported tenderness to palpation of the lumbar spine with no evidence of neurologic findings in the lower extremities. The injured employee did have a positive straight leg raise to the left. The injured employee was stated to have not responded to epidural steroid injections and follow-up on 07/20/2010, indicating that the patient had complaints of urinary incontinence. The injured employee was requesting additional injections and was recommended for discectomy fusion at L4-5. Dr. opined that the injured employee had evidence of bone lesions suggestive of metastatic process and further investigation was recommended to rule out metastatic bone cancer as a pain generator for the patient. Additionally, it did not appear that Dr. had an MRI available for review. Dr. opined that there was no evidence of nerve root compromise or significant degenerative disc disease, or motion segment instability that would warrant the requested surgical procedures. The injured employee did not respond to previous epidural steroid injections and no psychological evaluation was provided.

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

The clinical documentation provided for review does not support the request for surgery. The patient is noted to have mild canal stenosis at L4-5 and L5-S1 with mild degenerative changes; however, there is no clear evidence of nerve root involvement or significant motion segment instability that would reasonably require the two-level fusion requested. Additionally, the patient did not respond in the long term from epidural steroid injections, and epidural steroid injections in combination with surgery are not supported by guidelines. Additionally, no psychological evaluation is submitted for review that ruled out any confounding issues regarding the patient's response to surgery, and there was minimal clinical documentation regarding other areas of conservative care such as physical therapy, activity modifications and medication management. As the clinical documentation does not support the request, the prior denials for the requested surgical procedures are upheld.

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)