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Notice of Independent Review Decision

187858

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/28/2011

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ALIF L5-S1 1 day LOS

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- February 1, 2008 report by Dr.
- December 30, 2008 x-ray report by Dr.
- Chronic pain management program notes with somewhat difficult to interpret dates: August 13, 2008 start date noted in the September 2, 2008 date on another document
- November 17, 2008 report by Dr.
- November 28, 2007 through March 10, 2011 records from clinic
- February 15, 2011 and March 1, 2011 utilization review reports from provider
- October 5, 2007 lumbar spine myelography report by Dr.
- October 5, 2007 post lumbar myelogram CT report by Dr.
- April 26, 2010 lumbar MRI report by Dr.
- June 18, 2010 x-ray report by Dr.
- January 21, 2011 referral form from Dr.
- February 4, 2011 report by, Ph.D., clinical health psychologist
- March 18, 2011 letter.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX year old female who sustained an industrial injury on XX/XX/XXXX. On February 1, 2008, she underwent pedicle screw instrumentation at L3-4, L4-5 and posterolateral fusion and decompressive laminectomy. On February 4, 2008, she underwent L3-4, L4-5 corpectomy with anterior fusion with PEAK interbody cages.

The patient underwent lumbar spine x-rays on December 30, 2008 with evidence of hardware bridging at L3, L4 and L5. The hardware appears intact. There was metallic artifact in the L3-4 and L4-5 discs related to prosthetic placement. There was no evidence for fracture or subluxation.

The patient underwent lumbar spine x-rays on June 18, 2010 with an impression as follows: "1. Extensive post-operative changes in the lumbar spine as described with normal alignment maintained and no complicating process. 2. Moderate disc space narrowing at the lumbosacral junction." No spondylolisthesis or spondylolysis was noted.

A lumbar spine MRI was performed on August 26, 2010 with an impression as follows: "1. 8mm right paracentral disc protrusion at L5-S1-compresses the proximal right S1 nerve root and narrows the proximal right neural foramen. 2. 3-mm broad-based right postero-lateral disc bulge at L4-5 with mild right foraminal stenosis. 3. 3-mm broad-based left posterolateral disc protrusion at L3-4 with mild left foraminal stenosis. 4. Mild disc degeneration and diffuse annular bulge at L1-2 without focal disc protrusion or stenosis. 5. Extensive post surgical changes at L3-4 and L4-5 as described."

A January 20, 2011 note states that the patient was referred for a surgical referral from her pain management physician. She complains of back pain and severe pain down the right leg and a foot drop. She utilizes a cane to help walk. She has recently fallen as a result of this problem. Examination revealed EHL and plantar flexion strength 4/5 and decreased sensation in the right lower extremity in these dermatomes. The above captioned surgery was recommended. An anterior approach was recommended to avoid having to do anything from a screw removal and hardware removal standpoint at the other 2 levels. X-rays were taken on that date and reportedly revealed good position of the previous pedicle screw instrumentation at L3-4 and L4-5. She has interbody cages seen at these 2 levels. It appears to have bone formation within the cages and has the appearance of a solid fusion. At L5-S1, there is significant disc space narrowing and there are osteophytic changes along the facet joints.

The patient underwent a presurgical psychological screening on February 4, 2011 and she was cleared for surgery with a good prognosis for pain reduction and functional improvement.

On February 15, 2011, a non-certification was provided for the request of ALIF L5-S1. The report noted that the August 25, 2010 MRI fails to reveal any evidence of instability or spondylolisthesis that would necessitate a fusion. It was noted that the patient does have an 8-mm disc herniation, however, given the lack of evidence of instability or spondylolisthesis, the request for lumbar fusion is not medically necessary.

On March 1, 2011, the request was reviewed again and another non-certification provided. The report noted that the records did not discuss the claimant's treatment for the development of right leg complaints with appropriate conservative treatment. W hile the claimant does have weakness correlating with the MRI and has a history of prior fusion, on February 4, 2011, it was noted that she had a very good result after the 2 level fusion. Since July 2010, there is no indication that the claimant received an appropriate course of rehabilitation. It was noted that while the claimant has neurologic dysfunction, the records do not adequately define that this is a progressive neurologic dysfunction or was previously present.

A March 10, 2011 follow-up note indicates that the patient's 8-mm disc herniation used to be a 3-mm bulge. It is compromising the nerve root and causing pain and dysfunction of the right lower extremity to the point that she utilizes a cane to walk. She has weakness in the foot with EHL and dorsiflexion rated 4/5. Prior to this it was 4+/5. Prior to that it was 5/5. She has no sensation in the dorsum of her foot now. An anterior lumbar fusion at L5-S1 has been recommended to stabilize the segment. An iatrogenic instability would be created by just doing a decompression alone.

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

Given the patient's progressive neurologic deficit that has resulted in falling, conservative management is not indicated. The guidelines allow for fusion in the case of progressive neurologic dysfunction. Based on the patient's previous fusions at the levels above the L5-S1 level, which demonstrates an 8-mm protrusion, it is appropriate to proceed with fusion at the L5-S1 level to avoid the instability by performing a decompression alone. The patient has obtained psychological clearance and it is appropriate to now proceed with the requested surgery. Therefore, my recommendation is to overturn the decision to non-certify ALIF L5-S1 1 day LOS.

The IRO's decision is consistent with the following guidelines:

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

__x__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

According to the Official Disability Guidelines: Low Back Chapter
Fusion (spinal): Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients."

Lumbar fusion in workers' comp patients: 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. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." It appears that workers' compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. (Fritzell-Spine, 2001) (Harris-JAMA, 2005) (Maghout-Juratli, 2006) (Atlas, 2006) Despite poorer outcomes in workers' compensation patients, utilization is much higher in this population than in group health. (Texas, 2001) (NCCI, 2006) Presurgical biopsychosocial variables predict patient outcomes from lumbar fusion, which may help improve patient selection. Workers' compensation status, smoking, depression, and litigation were the most consistent presurgical predictors of poorer patient outcomes. Other predictors of poor results were number of prior low back operations, low household income, and older age. (DeBerard-Spine, 2001) (DeBerard, 2003) (Deyo, 2005) (LaCaille, 2005) (Trief-Spine, 2006) Obesity and litigation in workers' compensation cases predict high costs associated with interbody cage lumbar fusion. (LaCaille, 2007) A recent study of 725 workers' comp patients in Ohio who had lumbar fusion found only 6% were able to go back to work a year later, 27% needed another operation, and over 90% were in enough pain that they were still taking narcotics at follow-up. (Nguyen, 2007) A recent case-control study of lumbar fusion outcomes in worker's compensation (W C) patients concluded that only 9% of patients receiving WC achieved substantial clinical benefit compared to 33% of those not receiving WC. (Carreon, 2009) This large historical cohort study suggests that lumbar fusion may not be an effective operation in workers' compensation patients with disc degeneration, disc herniation, and/or radiculopathy, and it is associated with significant increase in disability, opiate use, prolonged work loss, and poor RTW status. (Nguyen, 2011) After controlling for covariates known to affect lumbar fusion outcomes, patients on workers' comp have significantly less improvement. (Carreon, 2010)

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.