

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/21/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5 partial corpectomy, L4-S1 anterior lumbar interbody fusion with Sovereign instrumentation, Bone Morphogenetic Protein, right L4-S1 decompression, Postero lateral fusion and spinal cord monitoring and 2 inpatient days

QUALIFICATIONS OF THE REVIEWER:

Orthopaedic Surgery, Surgery Trauma

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

L5 partial corpectomy, L4-S1 anterior lumbar interbody fusion with Sovereign instrumentation, Bone Morphogenetic Protein, right L4-S1 decompression, Postero lateral fusion and spinal cord monitoring and 2 inpatient days Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Patient is a xx year old male. He was injured when he was moving a ladder and the ladder got caught in some trees and he injured his low back. He was treated with non-steroidal antiinflammatory drugs (NSAIDS) and physical therapy and other treatment modalities. Radiographic studies were completed. These include MRI dated 11/23/09 with finding of degenerative disease lumbar spine, centered around L5-S1. A repeat MRI was obtained 5/11/10 demonstrating degenerative disease L5-S1 with disc bulge, there is a moderate focal central disc herniation with right paracentral disc compressing right S1 nerve sleeve. There was report of flexion/extension films, but this was not included. The injured employee (IE) has undergone PT for a year, with improvement noted; NSAIDS and narcotics pain meds; pain management and multiple epidural steroid injections (ESI). He was declared at maximum medical improvement (MMI) with 0% impairment. However, the claimant continues to complain of intractable back pain with radiation to his right, and now left leg; reported fecal incontinence and erectile dysfunction. The latest and most thorough exam, dated 10/6/10, states 4 minus hip extension, abduction, flexion, DF, PF and 4 plus quads strength. There are reports of decreased sensation right S1 nerve distribution.

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

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:

S1 nerve root compression, requiring ONE of the following:

- There is weakness documented, but of more than s1 nerve root. There is no mention of atrophy.

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:

- There is S1 nerve sleeve compression

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:

- MRI findings stated earlier. There is no mention of retrolisthesis or instability.

1. MR imaging

2. CT scanning

3. Myelography

4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- The IE has had work modification, tried numerous drug therapies and pt.

A. Activity modification (not bed rest) after patient education (>= 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)

For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

- The criteria are not all met.

The use of bone morphogenetic protein:

- The use of RHBMP 2 would be considered off label in this instance and thus is not approved.

For this injured employee, there is not unequivocal evidence of radiculopathy with weakness noted involving L3-4-5 nerve root distribution also. In addition, there are no official reports of instability with dynamic films and no indication of instability with MRI. The IE is a smoker and there has not been evidence of a smoking cessation program. There has not been psychological screening.

The recommendation is to uphold the previous denial.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Low Back - Lumbar & Thoracic (Acute & Chronic)

Spine (Phila Pa 1976). 2010 Sep 1;35(19):1794-800. Off-label use of bone morphogenetic proteins in the United States using administrative data. Ong KL, Villarraga ML, Lau E, Carreon LY, Kurtz SM, Glassman SD. Exponent Inc., Philadelphia, PA 19104, USA. kong@exponent.com

J Neurosurg Spine. 2007 Jul;7(1):21-6. Comparison of anterior- and posterior-approach instrumented lumbar interbody fusion for spondylolisthesis. Min JH, Jang JS, Lee SH. Department of Neurosurgery, Gimpo Airport Wooridul Spine Hospital, Seoul, Korea.

Spine J. 2003 Dec;12(6):567-75. Epub 2003 Aug 28. Comparison of instrumented anterior interbody fusion with instrumented circumferential lumbar fusion. Madan SS, Boeree NR. Southampton University, Southampton, UK