



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 1/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an inpatient lumbar surgery to include L4 to S1 lumbar laminectomy, discectomy, L5/S1 arthrodesis with cages, posterior instrumentation. (63030, 63035, 69990, 22612, 22851, 20938, 22840, 22558, 22325)

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. The reviewer has been practicing for greater than 10 years.

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 the prospective medical necessity of an inpatient lumbar surgery to include L4 to S1 lumbar laminectomy, discectomy, L5/S1 arthrodesis with cages, posterior instrumentation. (63030, 63035, 69990, 22612, 22851, 20938, 22840, 22558, 22325)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 12/16/10 denial letter, surgery code sheet, 9/21/10 surgical consult by Dr., 9/20/10 MRI scan review, 10/21/10 diagnostic screening report, 8/3/10 pt follow up report and 10/9/07 lumbar MRI report.

: 12/23/10 denial letter. (all other records were duplicates)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been noted to have failed reasonable non-operative treatment for a workplace-associated low back injury. Attending Physician records from xx/xx/xx denote the right-sided L5-S1 distribution of leg weakness and diminished ankle jerk. Paresthesias were noted in the L5 and S1 distribution. A 10/9/07 dated MRI revealed a midline HNP has been noted at L4-5, along with degenerative changes-spondylosis at other levels. The Attending Physician noted contained HNPs at L4-5 and L5-S1. The AP indicated that there was instability at L5-S1 on the flexion-extension films. Flexion-extension films did not reveal instability as per radiologist impression on 9/7/07. Denial letters noted the lack of instability on flexion-extension films and questions as to progression of neuro findings and/or exhaustion of conservative care.

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

The claimant's clinical findings support evidence of ongoing nerve root impingement at L5 and S1. However, documentation of the actual non-operative therapy and ESIs that have been attempted and failed has not been evidenced in the records submitted. In addition, prior records denoting neurologic abnormalities as being of greater or lesser severity have not been evidenced. Finally, there is a significant persistent question as to the existence of any guideline-associated segmental instability, which has been read as not present in a radiologist's interpretation of the prior-flexion and extension films. With these questions, applicable guidelines would not support the medical necessity of the proposed surgical procedures at this time.

ODG-Spine Chapter: 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. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees).] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical

activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. 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. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm).] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria.

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)