

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: July/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Exploration with Facetectomy at L5-S1, Fusion Removal Hardware, Left Lateral Foraminotomy and Laminectomy, Posterior Spinal Fusion at L4-S1 with Spinal Monitoring; 5 Days of In-Patient Hospital Stay

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates
Dr OV 12/09/10, 04/06/11
Dr. OV 09/11/03, 09/16/03, 11/25/03
Dr. OV 03/25/05, 04/02/09, 04/07/09, 06/04/09, 07/28/09, 08/04/09
Pre- surgical psychological evaluation 05/18/11
Lumbar myelogram / CT 10/12/04, 03/22/11
CT lumbar spine 10/12/03, 10/12/04, 9/11/09
MRI lumbar spine 08/19/03
X-ray lumbar spine 09/11/03, 09/16/03, 10/12/04
EMG/ NCS 09/29/03, 03/24/11
Pre authorization request
Medical Record Review Addendum 03/22/10
Peer Review 05/12/11, 06/03/11, 06/15/11
Laboratory studies 2003

PATIENT CLINICAL HISTORY SUMMARY

This is a male who reportedly sustained a back injury in xx/xx lifting a heavy piece of equipment. The records indicated that the claimant was status post L4- S1 decompression fusion, interbody and posterior fusion with cages and pedicle screws with severe back and leg pain. Conservative measures had included injections, extensive physical therapy, implantation of a spinal cord stimulator and medications. EMG/ NCS 03/24/11 and CT / Myelogram 03/22/11 demonstrates bilateral L5, S1 radiculopathies, hypertrophic facet joint left L5/S1 that is compressing the nerve roots, and a medially placed left S1 pedicle screw that impinges on the L5 root

An evaluation dated 04/06/11 revealed the claimant with continued back and leg pain with no recent physical therapy or injections. According to the treating physician, the claimant would benefit from additional lumbar surgery. A pre- surgical psychological evaluation completed on 05/18/11 noted the claimant an excellent candidate for proposed surgery with no contraindications. An Exploration with Facetectomy at L5-S1, Fusion Removal Hardware, Left Lateral Foraminotomy and Laminectomy, Posterior Spinal Fusion at L4-S1 with Spinal Monitoring; and 5 Days of In-Patient Hospital Stay was requested.

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

The requested Exploration with Facetectomy at L5-S1, Fusion Removal Hardware, Left Lateral Foraminotomy and Laminectomy, Posterior Spinal Fusion at L4-S1 with Spinal Monitoring; 5 Days of In-Patient Hospital Stay is not medically necessary based on review of this medical record. This is a male who had a previous L4-S1 fusion, and it would appear from the medical records provided to include a 03/22/11 lumbar CT myelogram report that the interbody fusion is solidly intact and mature. These tests do show some ongoing nerve root impingement at the L5-S1 level with a follow up abnormal EMG documenting acute and chronic bilateral L5-S1 radiculopathies. The ODG Guidelines document the use of revision lumbar fusion in claimants who have true evidence of pseudoarthrosis. That is not present in this case. There does not appear to be any clear documentation of pseudoarthrosis on CT scan report or evidence on abnormal motion on flexion/extension stress lateral X-rays. In light of the fact there is no documentation of pseudoarthrosis, there is no medical necessity for revision fusion surgery.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates:

Low Back: Lumbar fusion

Not recommended for patients who have less than six months of failed conservative care unless there is 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

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 unilateral neural arch hypoplasia.
- (2) Segmental Instability - 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
- (3) Primary Mechanical Back Pain/Functional Spinal Unit Failure, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability, with and without neurogenic compromise. 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.

(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

Surgical indications:

(1) All pain generators are identified and treated

(2) All physical medicine and manual therapy interventions are completed;

(3) X-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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

ODG hospital length of stay (LOS) guidelines

Lumbar Fusion, posterior : Best practice target (no complications) -- 3 day

Lumbar Fusion, anterior : Best practice target (no complications) -- 3 day

Lumbar Fusion, lateral : Best practice target (no complications) -- 3 days

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)