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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/14/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Posterior Spinal Fusion with Instrumentation and Decompression L3-4 and three day inpatient 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

Dr. office notes 02/02/06, 04/11/06, 07/05/06, 09/06/06, 11/07/06, 01/09/07, 02/06/07, 04/03/07, 06/06/07, 06/12/07, 07/17/07, 09/25/07, 03/25/08, 09/23/08, 04/07/09, 12/28/10, 04/12/11, 05/03/11

Operative report 06/13/06

Procedure report 01/19/11

Intra operative x-ray report 01/19/11

Peer review reports 04/19/11, 05/11/11

Carrier Letters to Dr. 04/22/11, 05/09/11, 05/11/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a XX year-old male with a work injury of XX/XX/XX. On 06/13/06 he underwent L4-5 and L5-S1 laminectomy/discectomy and posterior spinal fusion. He did well for approximately six months but then had complaints of low back pain. He continued to follow with Dr. for residual low back pain. On 12/28/10 the claimant underwent a lumbar MRI that demonstrated post op changes at L4-5 and L5-S1. At L3-4 there was a 2 mm posterior broad based disc bulge indenting the thecal sac abutting the traversing L4 roots. There was mild hypertrophic facet arthrosis but only mild central canal narrowing resulted. There was also bilateral foraminal narrowing, which might contact but did not compromise the exiting L3 roots. An L3-4 transforaminal epidural steroid injection was given on 01/19/11 with some relief for approximately two months. The only exam findings noted in the April and May 2011 visits were decreased range of motion and pain on motion of his back. The diagnosis was L3-4 disc herniation and stenosis above the previous fusion. Records indicate that the claimant has been following a home exercise program and taking ibuprofen.

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

This is a XX-year-old gentleman who had previous L4-L5 and L5-S1 decompression and

fusion surgery in 2006. Over time he developed residual progressive low back pain. He underwent a December 2010 lumbar MRI documenting small L3-L4 disc bulge without clear evidence of nerve root displacement. He has had conservative care with epidural steroid injection with short-term relief. A fusion has been requested. There is no documentation in the medical record of a recurrent disc herniation or structural instability, no documentation of progressive neurologic deficit or infection. Official Disability Guidelines document the use of spinal fusion in patients who have recurrent disc herniation or structural instability, none of that appears present in this case.

While this reviewer understands the concept of junctional stenosis and progressive instability at a level next to a prior fusion, that does not appear to be well documented in any of these medical records, therefore, the requested surgical intervention (Posterior Spinal Fusion with Instrumentation and Decompression L3-4 and three day inpatient stay) is not found to be medically necessary.

Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates. Low back

Spinal fusion

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 below. After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

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 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-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.

Length of stay

Lumbar Fusion, posterior (icd 81.08 - Lumbar and lumbosacral fusion, posterior technique

Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) \$86,90

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)