



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an anterior lumbar interbody fusion at L5-S1 (22614, 22612, 22840, 22585, 22851, 63005, 20930).

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 anterior lumbar interbody fusion at L5-S1 (22614, 22612, 22840, 22585, 22851, 63005, 20930).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The has been documented as having persistent lower back pain with lower extremity radiation, with paresthesias. Treatments have included medications, therapy and epidural steroid injections. Diagnoses have included displaced intervertebral disc. Institute records from 6/11/10 and thereafter were reviewed. The injury mechanism involving a fall and lifting was reviewed. A 6/11/10 dated flexion-extension x-ray revealed the lack of lumbar/sacral instability. Pain Medicine records from 4/26/10 were also reviewed. Reference was made to an MRI dated 5/24/10 denoting a disc protrusion with Neuroforaminal narrowing at L5-S1. A lesser bulge was noted at L4-5. SLR was positive bilaterally. Electrical studies dated 7/6/10 revealed a lack of specific radiculopathy, and, some peripheral neuropathies. The 8/16/10 dated designated doctor evaluation revealed that the claimant had an ongoing aggravation of DDD, especially at L5-S1. Therapy records were reviewed, as were the ESI procedure notes. "Lasar Spine Specialists" notes were reviewed, including from 9/8/10. There was a consideration for a spinal fusion at L5-S1. The 11/2/10 dated psych evaluation (for work hardening) was reviewed. Assoc. records from 2/11/11 were reviewed. Painful back motion was noted with a normal neurological exam, without evidence of instability was noted.

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

Without guideline-associated flexion/extension x-rays documenting instability, there is no support for the proposed fusion at L5-S1. In addition, a recent psychosocial screen has not been submitted for review. Finally, definitive pain generation from the proposed site of surgical intervention has not necessarily been established at this time; therefore, the requested treatment is not medically necessary.

ODG Lumbar Spine 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, with 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. Spinal instability criteria includes 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.

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

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 KNOWLEDGBASE
- 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)