



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 10/27/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of 1-2 day inpatient stay for posterior lumbar interbody fusion of L4/5 and L5/S1 at Harlingen Medical Center.

**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 1-2 day inpatient stay for posterior lumbar interbody fusion of L4/5 and L5/S1 at Harlingen Medical Center.

**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: MD letter – 10/17/11; ODG chapter regarding Patient Selection Criteria for Lumbar Spinal Fusion; LHL009 – 10/13/11; Denial Letters – 8/19/11 & 9/6/11; Risk Management Fund Determination Letters – 4/8/11, 8/16/11, & 8/31/11, Pre-Authorization Requests – undated & 8/31/11; MD email – 8/19/11; Doctors Hospital MRI report – 3/7/11; MD Electromyography and Nerve Conduction Velocity Report – 6/30/11; Spine & Neurological Surgical

Imaging Report – 8/25/11, Office Visit Notes – 5/17/11-10/11/11; and, MD Office Note – 3/28/11.

Records reviewed from MD: All records were duplicates from above.

A copy of the ODG was provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The was injured on xx/xx/xx. There has been low back pain with left leg radiation, despite comprehensive non-operative intervention. The 3/7/11 dated lumbar MRI revealed a grade 2 spondylolisthesis at L5-S1 with pars lysis at L5, with severe bilateral foraminal narrowing at L4-L5, along with a disc protrusion (right-sided.) Multi-level disc protrusions and facet hypertrophy was noted. Treating notes from the provider (a Dr.) were reviewed including from 5/17/11 and thereafter. Grade 4/5 strength was noted of the tibialis anterior (with limited effort), along with a + straight leg raise. Sensation was decreased in the L3 and L5 distribution, 1+ left knee and ankle reflexes were noted. 6/30/11 dated electrical studies were reported to be normal. On 8/15/11, there was back pain with bilateral leg radiation noted. Objective neurological exam findings were not documented. Discectomy and fusion were felt indicated by the Dr.. An 8/25/11 dated Ct-myelogram revealed findings similar to the MRI, along with stenosis (central and foraminal), and a mass-like density behind the L3 vertebral body. On 8/30/11, exam findings included normal symmetric reflexes, a weak (4/5 EHL) and decreased left L5 sensation. Decompression with wide facetectomy and fusion were felt indicated by the Attending Physician. This was reiterated on 10/11/11. Denial letters reflected a lack of instability at L4-5 and/or inconsistent neurologic abnormalities on exam.

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

ODG Guidelines support fusion when there is segmental instability documented via flexion-extension x-ray images. These studies have not been documented to have taken place. In addition, there is no documentation of a psychosocial screen having taken place, which is another guideline-associated criterion. The selection criteria for lumbar spine fusion have not been met at this time. Therefore, neither the proposed surgical procedure nor the hospitalization is medically necessary at this time, as per clinical guidelines.

Reference: ODG Lumbar Spine-Spinal Fusion

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, 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 & 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).

ODG hospital length of stay (LOS) guidelines:

Discectomy (*icd 80.51 - Excision of intervertebral disc*)

Actual data -- median 1 day; mean 2.1 days ( $\pm 0.0$ ); discharges 109,057; charges (mean) \$26,219

Best practice target (no complications) -- 1 day

Lumbar Fusion, posterior (*icd 81.08 - Lumbar and lumbosacral fusion, posterior technique*) Actual data -- median 3 days; mean 3.9 days ( $\pm 0.1$ ); Best practice target (no complications) -- 3 days

Lumbar Fusion, anterior (*icd 81.06 - Lumbar and lumbosacral fusion, anterior technique*) Actual data -- median 3 days; mean 4.2 days ( $\pm 0.2$ ); Best practice target (no complications) -- 3 days

Lumbar Fusion, lateral (*icd 81.07 - Lumbar fusion, lateral transverse process technique*) Actual data -- median 3 days; mean 3.8 days ( $\pm 0.2$ ); 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- 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)