



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 12/5/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of L5-S1 laminectomy, discectomy and fusion with instrumentation, inpatient stay times one day.

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.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of L5-S1 laminectomy, discectomy and fusion with instrumentation, inpatient stay times one day.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

- Pre-Authorization Request – undated
- Appeal - undated
- Office Visit Notes – 8/14/12, 9/25/12
- New Patient Surgical Consultation – 5/10/11
- MRI Scan Review – 5/9/11
- Radiograph Report – 8/22/12
- Psychological Reassessment for Pre-surgical Evaluation – 8/27/12
- Patient Follow-up/Re-Exam – 4/4/11

MRI report – 3/7/11
Pain Management Follow-up Visit – 4/11/11
Pain Management Procedure Note – 4/7/11
Electrodiagnostics of the Lower Extremities – 6/1/11
Patient Follow-up/Re-exam Notes – 4/11/12, 5/11/12, 6/11/12, 7/10/12,
8/9/12
New Patient Evaluation – 9/24/12
Operative Report – 6/4/12
Texas Department of Insurance:
Decision and Order – 2/6/12
Denial Letters – 10/8/12 & 10/12/12

Records reviewed
LHL009 – 10/15/12
Surgery Checklist - undated

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The Attending Physician and pain management records were reviewed. The claimant was noted to have been injured while lifting on the DOI. As of 9/25/12, the patient was noted to have persistent back and bilateral leg pain. The Attending Physician detailed a “functional unit collapse” at L5-S1 on the standing lateral. This was noted to meet the clinical instability criteria of ODG, as per the Attending Physician (who discussed 9 mm of collapse) on motion films. The diagnosis was that of lumbar HNP with clinical instability at L5-S1, along with failure of conservative treatment for years. The failed conservative treatment was detailed on 8/14/12. It included chiropractic care, physical therapy and multiple sets of ESIs. The examination findings (that were persistent as of 9/25/12) included a hypoactive right-sided ankle jerk, hypoactive right gastroc-soleus, and paresthesias in the L5 and S1 nerve root distribution on the right, S1 nerve root distribution on the left. On 8/22/12, flexion extension films revealed a 3 mm shift at L2-3 and L3-4. The 3/7/11 dated MRI findings were noted to reflect “discal pathology at L5-S1 and possibly at L3-4 and L4-5.” Spinal stenosis was also noted. The 8/27/12 dated psychosocial clearance was noted. 6/1/11 dated electrical studies revealed S1 radiculopathy. Denial letters denote a lack of neurocompressive lesion on MRI, along with an apparent discrepancy regarding the flexion-extension film reports.

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

The subjective complains of back and leg pain correlate with the objectively abnormal neurologic deficit on clinical examination. The electrical studies corroborate S1 radiculopathy. The ODG criteria for fusion include "Primary Mechanical Back Pain" and "Functional Spinal Unit Failure/Instability." There has been a documented detailed Attending Physician description of both clinical and electrically-corroborated radiculopathy. In addition, function unit collapse has also been documented. A recent comprehensive non-operative treatment protocol has been documented to have been tried and failed. A psychosocial screen has been documented.

ODG Low Back: 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. (Andersson, 2000) (Luers, 2007)] (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.

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 correlated with symptoms and exam findings; & (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. (Colorado, 2001) (BlueCross BlueShield, 2002) For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

Overall guideline criteria for decompression of radiculopathy and fusion of the affected L5-S1 area have been met; therefore, the requested service is medically necessary.

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)**