ReviewTex
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Notice of Independent Review Decision

DATE OF REVIEW: 02/09/12

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Requested Services:

CPT:	Description:	Request Date:	Determ Date:
20936	Autograft for Spine Surgery	01/09/12	01/17/12
22558	ARTHRODESIS-ANT INTERBODY TECH:	01/09/12	01/17/12
22612	Posterior Lumbar Fusion	01/09/12	01/17/12
22614	Arthrodesis:posterior/posterolateral:each add'	01/09/12	01/17/12
22842	Spinal Instrumentation	01/09/12	01/17/12
22845	ANTERIOR INSTRUMENTATION	01/09/12	01/17/12
22851	Application of Prosthetic Device	01/09/12	01/17/12
63047	Lumbar Laminectomy	01/09/12	01/17/12
63048	Additional Segment	01/09/12	01/17/12
95920	Intraoperative Neurophysiology testing:per ho	01/09/12	01/17/12
95937	Neuromuscular Junction Testing	01/09/12	01/17/12
RC110	Inpatient Non-Surgical Room	01/09/12	01/17/12

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Behavioral medicine consultation dated 11/23/92
2. Clinic notes Dr. dated 01/12/93-06/28/11
3. Report of lumbar discography dated 09/23/92

4. Impairment rating dated 01/27/94
5. Clinic notes Dr. dated 03/02/99-04/29/99
6. Clinic note Dr. dated 03/06/01
7. MRI lumbar spine 12/13/10
8. Clinic notes Dr. dated 08/29/11-10/24/11
9. CT myelogram of lumbar spine dated 10/10/11
10. Psychological evaluation dated 11/28/11
11. Utilization review determination dated 12/30/11
12. Utilization review determination dated 01/17/12

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who is reported to have sustained work related injuries on xx/xx/xx. On the date of injury she was walking through a doorway and tripped. She was reported to have struck the back of her head and lost consciousness. She was further noted to have history of previous lumbar fracture in 1989. Records indicated the claimant was identified as having disc disruptions at L2-3 and L3-4.

She underwent lumbar discography on 09/23/92 which was reported to have produced back pain and bilateral leg pain at L2-3 and L3-4 with negative controls at L4-5 and L5-S1. She subsequently was taken to surgery and underwent 360 degree fusion from L2-4 on 01/20/93. Postoperatively the patient was reported to have 7% whole person impairment on 01/27/94. Records indicated the patient had significant improvement with this procedure. In 2001 she developed adjacent segment disease below the level of fusion. She later underwent CT myelogram of lumbar spine. She was recommended to later undergo removal of instrumentation. The patient was largely maintained on oral medications.

On 08/29/11 the patient sought care from Dr.. At that time she reported worsening back pain and weakness, numbness and tingling in bilateral legs aggravated by activity. She reported occasionally her left leg will go out completely. She was told she should have screws taken out 2 years after surgery. It was noted the patient had a fracture and was treated with global fusion at L2-3 and L3-4. She returned to work and was noted to be working.

MRI of lumbar spine dated 12/13/10 notes status post L2-4 global fusion with L1-2, L4-5, L5-S1 HNP and degenerative disc disease due to instrumentation. On physical examination she was 63 inches tall and weighed 170 lbs. She had full pain free range of motion of bilateral lower extremities. She had symmetrical quad and Achilles reflexes. She had healed midline lumbar rand right iliac crest bone graft incision. Motor strength was 5/5 in lower extremities. She was recommended to undergo CT myelogram which was performed on 10/10/11. This study noted post surgical changes from a prior fusion from the L2 through 4 levels with bilateral L2 and L4 transpedicular screws posterior rods. There were cerclage wires noted along the C2 and C3 or L2 and L3 spinous

processes. There was complete osseous fusion across at L3-4 and L4-5 disc spaces. There was a broad based small central bilateral paracentral disc protrusion at the L4-5 level. There was moderate bilateral degenerative facet disease changes mild to moderate flattening of the bilateral recesses left greater than right. There was a small left paracentral disc protrusion at the L5-S1 level associated moderate to severe degenerative facet changes. Moderate flattening of the left lateral recess and mild with mild mass effect upon the left S1 nerve roots.

The patient was seen in follow-up by Dr. on 10/24/11. Physical examination was unchanged. It's opined that the claimant has neural impingement on the left at L4-5 due to HNP which was opined to be the cause of her left lower extremity pain and numbness. The claimant was recommended to undergo a revision with ALIF and PISF at L4-5 and L5-S1 with removal of L2 through L4 instrumentation. The record included a psychiatric evaluation performed on 11/28/11. She was noted to be psychologically stable and was not experiencing any significant depression or anxiety she was subsequently cleared for surgical intervention.

On 12/30/11 the initial review was performed by Dr. who noted that there was no documentation of a non-union from the prior surgery and that the claimant had not been documented to have evidence hardware failure and has no documentation of neural arch defect or segmental instability to support the requested procedure.

The subsequent appeal request was reviewed on 01/17/12 by Dr. who non-certified the request noting that the previous non-certification was supported. It was reported that the requested procedure was not documented and due to the fact that there is no stated non-union of the prior surgery of lumbar fusion from L2-4 he noted there was no evidence of instability on CT and that the claimant had not undergone any type of hardware block and that there's no evidence of radio lucency or failure of hardware or segmental instability at L4-5 and that peer review guidelines indicated that when that spinal fusion was indicated for segmental instability. He noted that the patient had not undergone any type of hardware injection block has a diagnostic examination as a source of back pain.

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

The request for L4-5 360 degree fusion with L2-4 hardware removal with four day inpatient stay is supported as medically necessary. The submitted clinical records indicate that the claimant is status post an L2-3 L3-4 fusion as a result of a slip and fall. The clinical records indicate that the claimant has had continued low back pain focal low back pain without evidence of radiculopathy on examination she's undergone multitude of diagnostic studies she has been treated conservatively with oral medications and physical therapy without any sustained improvement. The records indicate that the patient has adjacent segment disease at the level below the prior fusion. The claimant has been

unable to disregard below the level of fusion. In order to fuse the L4-5 level the L2-4 hardware will require removal and the hardware block is immaterial.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

References:

Fusion (spinal)

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. 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. (Andersson, 2000) (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. (See ODG Indications for Surgery -- Discectomy.)

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. (Colorado, 2001) (BlueCross BlueShield, 2002)

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