



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a laminectomy with fusion and instrumentation @ L4-L5 LOS 1 and purchase of a TLSO back brace (99222, 63030, 63035, 22630, 22851, 20937, 22842, 22612, 22614, 20975, 37202, 11981, and L0320).

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 a laminectomy with fusion and instrumentation @ L4-L5 LOS 1 and purchase of a TLSO back brace (99222, 63030, 63035, 22630, 22851, 20937, 22842, 22612, 22614, 20975, 37202, 11981, and L0320).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Healthcare and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Healthcare: Denial Letters – 10/6/11 & 10/28/11; Office / Clinic Notes – 7/19/11 & 7/22/11; MD DDE report – 3/26/10;

MD Letter of Medical Necessity – 9/29/11, Office Notes – 5/3/10-8/4/11; Ph.D. Psychological Evaluation – 2/18 & 2/28/11; Hospital Operative Report, Lumbar Myelogram Report, CT Evaluation Lumbar spine – 7/13/10, MRI Lumbar Spine – 6/14/10; and Medical Center Non-enhanced MRI Lumbar Spine – 6/10/10.

Records reviewed from MD: Office Notes – 9/29/11-10/24/11.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was struck on the back by a with severe injury to his left kidney. The first 6 months post injury was primarily associated with kidney issues. The patient complains of severe chronic mechanical lower back pain with instability, radiating hip and leg pain, numbness and weakness in the legs. Exam findings revealed bilateral positive straight leg raise, weakness of the foot and great toe dorsiflexors, severe paralumbar muscular tightness and decreased lumbar lordosis. Ongoing treatment has included hydrocodone. A 7/13/10 dated CT lumbar myelogram revealed (per the radiologist) multilevel lumbar disc bulges/spinal stenosis with mild to moderate thecal sac involvement, along with an 8mm oval subtle lucency involving the posterior aspect of the iliac crest; A prior 6/14/10 dated MRI lumbar spine report revealed (as per the radiologist) severe multilevel spondylitic/degenerative changes/stenosis. A 2/11 dated psychological evaluation revealed that the patient was cleared for surgical intervention. The Attending Physician indicated that surgical intervention was appropriate in order to prevent further neurological deficit and treat foot drop, pain etc. He documented stenosis, disc herniation and retrolisthesis, the later indicating instability. Denial letters discussed the lack of documentation of comprehensive non-operative treatment, evidence of instability and unknown smoking status.

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

The most recent imaging studies (CT and MRI, lumbar) did not reveal either nerve root impingement and/or segmental instability (as noted by flexion-extension films per ODG). There was no documentation of smoking status (impacts on potential healing of a spinal fusion). There is a lack of documentation evidencing a trial and failure of recent comprehensive non-operative treatment, as per applicable clinical criteria in ODG. Therefore, the proposed aggregate of requested procedures is not medically necessary as they do not meet the ODG-associated clinical criteria for such an aggregate of procedures (especially the fusion portion.)

ODG Lumbar Fusion: 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.

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)
- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

- A. Activity modification (not bed rest) after patient education (≥ 2 months)
 - B. Drug therapy, requiring at least ONE of the following:
 - 1. NSAID drug therapy
 - 2. Other analgesic therapy
 - 3. Muscle relaxants
 - 4. Epidural Steroid Injection (ESI)
 - C. Support provider referral, requiring at least ONE of the following (in order of priority):
 - 1. Physical therapy (teach home exercise/stretching)
 - 2. Manual therapy (chiropractor or massage therapist)
 - 3. Psychological screening that could affect surgical outcome
 - 4. Back school
- 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 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)**