

Notice of Independent Review Decision

DATE OF REVIEW: 03/02/2012

AMENDED DATE: 03/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Inpatient Anterior-Posterior Lumbar Fusion L5-S1 times 3 days LOS

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

MD- Board Certified Orthopaedic Surgeon who holds a Texas Medical License.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Request for review by IRO for the denied service(s) of anterior posterior lumbar fusion L5-S1	02/10/2012
Notice of Utilization review findings from	01/24/2012
Notice of Utilization review findings from	01/26/2012
A report from	08/11/2011
MRI of the lumbar spine	08/17/2011
A report from	08/26/2011
An outpatient rehabilitation services	09/02/2011
A report from	09/21/2011
An outpatient rehabilitation services	09/21/2011
A consultation report from	10/06/2011
An operative report	10/06/2011
A progress note from	10/14/2011



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A physical therapy initial evaluation	10/17/2011
An outpatient rehabilitation services	10/25/2011
An outpatient rehabilitation services	11/09/2011
An outpatient rehabilitation services	12/07/2011
A progress note from	12/19/2011
MRI of the lumbar spine	01/04/2012
A progress note from	01/16/2012
A progress note from	01/30/2012
An outpatient rehabilitation services	11/09/2011
An outpatient rehabilitation services	12/07/2011
A letter from to	02/01/2012

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is male who injured his lower back while working. He also complained of radiating pain to his left leg. He was seen by who recommended MRI of lumbar spine. He had MRI done on 08/17/2011 that showed a 6 mm at L4-5 HNP. He then underwent L4-5 discectomy on 10/06/ which was done by, but still complained of back pain with radiating pain to both legs, right more than left. He then had a repeat MRI done on 01/04/2012 that showed post surgical changes at L4-5 and residual disc protrusion centrally and also traversing left L5 and bilateral L4 nerve roots. He was recommended for anterior posterior lumbar fusion L5-S1 by which is denied by insurance.

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

After reading the records submitted by the treating physician and carrier as well as the initial and appeal reviewer, I agree that the ODG's were not met. Upon further review of the diagnostics I focused on the operative report. The operation had on 10/06/2011 was not performed using traditional orthopedic operative standards, rather was a newer improved minimally invasive technique that was not apparently successful. Fusion is not indicated per ODG (6). Manual therapy consult should also be done per ODG (ODG Pre-Operative Surgical Indications Recommends "All physical medicine and manual therapy interventions are completed").

PER ODG- 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



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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 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).



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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)