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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 10/27/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an inpatient L4/5 open 360 fusion with 2 day inpatient stay.

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 an inpatient L4/5 open 360 fusion with 2 day inpatient stay.

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: 8/14/12 surgery scheduling report, 2/8/12 patient profile, 8/16/12 chart summary, 8/24/12 behavioral eval report, 8/6/12 to 8/14/12 office visit notes, 2/23/11 to 6/25/12 follow up notes, 7/14/12 lumbar MRI report, 3/28/12 operative report, and 2/17/03 to 3/3/03 notes.

: patient account detail, 8/20/12 service authorization, 8/21/12 service authorization, 9/17/12 denial letter, 9/27/12 denial letter, 10/5/12 office notes by, 5/8/12 denial letter, 5/16/12 denial letter, 6/7/12 UR finding, 5/23/12 lab report, 11/8/11 drug screen request, 6/29/12 service authorization, 3/28/12 short stay physical report, 6/8/10 to 1/25/11 follow up reports, various DWC 73 forms, and 9/7/10 RADAR report.

Forte: all records were duplicative of those noted above.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a back injury. He has continued to have back pain despite meditations, injections, therapy and a lumbar fusion (and hardware removal.) 2/2/12 dated x-rays showed a retrolisthesis and “disc space collapse” at L4-5. A 7/16/12 dated lumbar MRI revealed L4-5 stenosis and “mild disc space” narrowing, along with an anterior spur and posterior synovial cyst and disc protrusion narrowing the foraminal space. AP canal diameter was 5 mm, with “severe” central canal stenosis. Most recently on 8/14/12, back pain with “progressive” sciatica and lower extremity paresthesias and intact motor strength with hyper-reflexic ankles. The patient is noted to smoke a pack of cigarettes daily. X-rays were compatible with a prior fusion at L5-S1. Desiccation and stenosis were noted at L4-5, as was facet hypertrophy and “transitional syndrome” Denial letters denoted constant back pain and a smoking history, along with a lack of documented segmental instability, a positive response to SI injections and the lack of extensive pre-operative rehabilitation.

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

There is a reported failure of non-operative treatments in the setting of “progressive” back pain and sciatica with paresthesias and hyperreflexia. However, there is also evidence of a significant ongoing smoking habit. In addition, there is no definitive evidence of segmental instability (as per guideline criteria) on the lateral flexion-extension films. “Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm.” Therefore, guideline criteria have not been fully met for the fusion portion of the request and the overall aggregate of the proposed procedures are not reasonable or medically necessary at this time.

Reference: ODG Lumbar Spine. 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. (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.

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)