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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 2/5/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of IP Sx Lumbar, decompressive laminectomies/foraminotomies L5-S1, lateral transverse fusion with pedicle screw fixation L5/S1, transverse lateral interbody fusion with cage L5/S1 and 3 day LOS.

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 IP Sx Lumbar, decompressive laminectomies/foraminotomies L5-S1, lateral transverse fusion with pedicle screw fixation L5/S1, transverse lateral interbody fusion with cage L5/S1 and 3 day LOS.

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: 1/21/13 letter from iod incorporated, 10/8/12 WC surgery request form, 10/4/12 CT myelogram report, 10/1/12 CT myelogram with post CT report, 7/5/12 to 9/13/12 office reports, 6/27/12 lumbar MRI report, and 6/27/12 left bicep MRI report.

12/7/12 denial letter, 10/12/12 denial letter, 7/19/12 to 8/16/12 reports, handwritten Nursing notes 7/6/12 to 10/9/12, 10/24/12 letter, PT, 8/8/12 rehab evaluation report, 8/13/12 to 9/20/12 daily therapy treatment notes, 8/8/12 to 9/12/12 exercise flow sheet, 7/6/12 patient information sheet, and 7/5/12 to 10/4/12 office reports.

12/1/12 report, handwritten Nursing notes 7/6/12 to 1/11/13, 8/13/12 to 1/16/13 daily therapy treatment notes, and 12/18/12 rehabilitation evaluation.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured resulting in ongoing low back pain with right leg radiation. Treatments have included restricted activities, Pt, medications and ESIs. Most recently on 10/4/12, a slightly decreased right ankle reflex was noted. There was a consideration for decompression and fusion at L5-S1. records revealed (most recently on 1/11/13), that there were sensory changes in the lower extremities. Prior records reflected PT notes. A prior 10/1/12 dated CT-myelogram revealed bilateral L5 spondylosis and grade 1 spondylolisthesis. Stenosis was noted to be moderate at L5-S1, including both central and foraminal. A 6/27/12 dated lumbar MRI report revealed mild degenerative changes with a 3mm anterolisthesis at L5-S1. Bulges at other levels, along with right-sided nerve root impingement at L4-5 and mild bilateral impingement at L5, along with possible pars defects at L5 were also noted. Denial letter reflected the lack of PT and injection records, along with the lack of a psychosocial screen and imaging evidence of segmental instability.

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

The submitted records adequately support that non-operative treatments have been tried and failed. However, complete fusion criteria have not been met. ODG indicates that there should be imaging evidence of spinal segmental instability documented. This has not been documented via flexion-extension lateral x-ray studies. In addition, a psychosocial screen (with resolution of any confounding issues) has not been provided. Therefore, medical necessity has not been established at this time.

Reference: ODG Low Back Chapter. 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. (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.

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)