



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 4/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of a bone graft, exploration of spinal fusion, spinal instrumentation, application of prosthetic device, neurolysis lumbar fibrosis, decompression of nerve, intraoperative neurophysiology testing , somatosensory testing – lower limbs, inpatient surgical room, algrft spi surg only morselized, insert pelv fixation device, and fusion of sacroiliac joint.

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.

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 bone graft, exploration of spinal fusion, spinal instrumentation, application of prosthetic device, neurolysis lumbar fibrosis, decompression of nerve, intraoperative neurophysiology testing , somatosensory testing – lower limbs, inpatient surgical room, algrft spi surg only morselized, insert pelv fixation device, and fusion of sacroiliac joint.

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:

SOAP Notes – 7/19/10, 9/20/10, 1/24/11, 3/28/11, 5/23/11, 6/20/11,
8/29/11, 10/10/11, 11/14/11, 11/28/11, 12/30/11, 4/30/12, 6/25/12,
10/9/12, 2/5/13, 3/12/13

Office Visit Report – 7/19/10

CT Myelogram Lumbar Spine Report – 6/11/12

CT L Spine w/o contrast – 11/21/11

DX L Spine 2 to 3 VW – 6/17/11, 11/21/11

Thoracic Spine X-rays & Lumbar Myelogram and CT – 8/20/10

New Patient Evaluation – 10/15/12

OC Therapy Eval & Discharge Summary – 5/28/11

PT Assessment & Physician's Order for Treatment – 5/28/11

Pre-surgical Psychological Evaluation – 9/30/10

Interim History and Physical Reports – 2/16/12, 3/15/12, 4/26/12

Operative Reports – 2/28/12, 3/29/12

Electrodiagnostic Testing – 9/10/10, 12/15/11

Records reviewed:

Adverse Determination Letters – 2/11/13, 4/9/13

Work Comp Pre-auth Request Form – 2/6/13

Reconsideration Work Comp Pre-auth Request Form – 3/12/13

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The female was injured in xx/xx. The mechanism of injury has not been provided. Despite two previous spinal fusions the claimant has persistent back pain. The initial fusion was done in 2002 from L4 to S1. The fusion was extended in May 2011, to the level of L2-L4. The fusion was noted to be radiographically solid prior to the extension of the fusion in 2011. Electrical studies from 12/15/11 revealed acute and chronic L5 radiculopathy. A CT-Myelogram from 6/11/12 documented the persistent fusion and retained hardware, with breakdown (at the L1-L2 level) above the prior fusion, along with some scoliosis and some SI joint degenerative changes. Treatments have included medications, restricted activities, therapy and epidural steroid injections all without maintained benefit. Recently as of 3/12/13, there was documented persistent back pain with radiation

into the legs. There was 4/5 left psoas strength and 3+ equal and symmetric reflexes in the lower extremities. There was a positive left straight raise. There were no recent documented physical examination findings at the sacroiliac joints or any documented recent trial and failures of injection treatments to those areas. Denial letters noted that objective findings provided did not meet guideline criteria.

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

Applicable clinical guidelines would not support the request at this time due to the lack of significant documented examination abnormalities of the affected sacroiliac joint. In addition, less invasive attempts to treat the reported painful degenerative abnormalities of the sacroiliac joint has not been documented. Finally, prior imaging and/or intraoperative studies have not evidenced radiologist corroboration of instability and/or a spinal nonunion.

ODG-Low Back Chapter:

Spinal 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 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).

Indications for SI Joint Fusion:

- Failure of nonoperative treatment- Chronic pain lasting for years- Diagnosis confirmed by pain relief with intraarticular sacroiliac joint injections under fluoroscopic guidance - positive response to the injection was noted, and patients had recurrence of symptoms after the initial positive - Preoperative and postoperative general health and function assessed - Medical records and plain radiographs have been reviewed retrospectively to determine the clinical and radiographic outcome

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)**