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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 9/4/13

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of 3 day LOS for L1/2 decompression and fusion with removal of lumbar hardware at L2/3 and placement of new hardware at L1/2.

### **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 3 day LOS for L1/2 decompression and fusion with removal of lumbar hardware at L2/3 and placement of new hardware at L1/2.

### **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: 7/31/13 denial letter, 8/13/13 denial letter, undated preauth request, 7/22/13 rationale for surgery letter, daily notes 1/4/13 to 7/22/13, 1/4/13 to 7/22/13 interval history reports, 4/25/13 lumbar trigger pt injection report, 7/2/13 lumbar CT myelogram report, 6/12/13 lumbar MRI report, 5/29/13 lumbar x-ray report, 7/16/13 psychological report, 8/5/13 request for

reconsideration letter, 7/26/13 LSO script, 7/26/13 DME script, 7/26/13 bone growth stimulator script, 1/25/13 series report, 1/18/13 handwritten medication letter, 1/18/13 cervical x-ray report, and 1/18/13 lumbar x-ray report.

All records were duplicative of those sent by the URA.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant was injured, although the injury mechanism to the low back was not provided at this time. The records reveal that the claimant had undergone multiple prior lumbar surgical procedures. A CT myelogram dated 7/2/13 revealed a disc bulge and retrolisthesis at L1-2, moderate stenosis and a prior fusion with retained hardware. Flexion-extension x-rays were negative for segmental instability. A psychosocial screen was unremarkable and non-confounding. A prior 6/12/13 dated lumbar MRI revealed findings similar to the CT-myelogram. Denials discussed the lack of a definitive pain generator, lack of correlation between motor weakness and surgical level requested, lack of instability and lack of conservative care. The AP has indicated that instability would be created by hardware removal without fusion. The 8/5/13 dated AP appeal letter discussed the symptomatic “junctional syndrome” at L1-2 including sciatica and lower extremity weakness resulting in falls. The AP has indicated that the imaging reveals severe L1-2 stenosis along with an L2-S1 solid fusion, instability represented by retrolisthesis at L1-2 and escalating symptoms including increasing patient falls despite the use of a cane. The L1-2 symptoms and objective proximal motor weakness including iliopsoas and quads (plantar dorsiflexion weakness was also noted) are felt by the AP to be consistent with imaging, along with segmental spinal unit failure. The AP indicated that prior treatments of injections, therapy and medications failed.

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

There is a lack of detailed provision of recent and comprehensive non-operative treatments tried and failed. There is a lack of definitive identification of the hardware and even the L1-2 segment as being definitive symptom generators and/or source of any instability. Therefore, requisite guideline criteria have not been met as referenced below in the Pre-Operative Surgical Indications 1-3.

Reference: ODG Lower Back Chapter

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 include 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.

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.

The requested procedure is does not meet criteria of the ODG based upon the medical records provided. Therefore, it is found to be not medically necessary at this time.

**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)