



Specialty Independent Review Organization

**Date notice sent to all parties:** 6/1/2016

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an L5-S1 mini 360 fusion and decompression with 3 days in-patient 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.

**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 L5-S1 mini 360 fusion and decompression with 3 days in-patient stay.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Injury mechanism included a slip and fall on XXX with an apparent low back injury. A lumbar MRI scan from XX/XXXX was noted to reveal a pars defect at L5 with a 10% spondylolisthesis. A disc protrusion was noted at L5-S1. Slight thecal sac flattening and neural foraminal protrusion was noted. There was also evidence of severe left sided foraminal stenosis with left L5 neural compression. Foraminal stenosis was noted at L5 and S1. A psychosocial report from XX/XX/XX did not support surgical intervention at that time. The most recent medical records submitted included from XX/XX/XX. There was ongoing back pain with radiation into the legs. It was determined to be along an L5 distribution. Diagnoses were noted to include spondylolisthesis and a lumbar disc abnormality along with low back pain and sciatica. Treatments included medications, altered activities, physical therapy and an epidural steroid injection (6/15). Denial letters discussed the lack of recent subjective or objective findings along with the lack of recent psychosocial screening and/or completion of a pain program that had been previously reportedly considered.

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

Recent findings evidencing subjective and/or objective findings, comprehensive tried and failed non-operative treatment and/or successful psychosocial screening (with resolution of prior poor prognosticators) are not evident. Guideline criteria have not been met as referenced below. Therefore, the request is not medically necessary.

Reference: ODG Low Back Chapter

Patient Selection Criteria for Lumbar Spinal Fusion:

(A) Recommended as an option for the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment (unless contraindicated e.g. acute traumatic unstable fracture, dislocation, spinal cord injury) subject to criteria below:

- (1) Spondylolisthesis (isthmic or degenerative) with at least one of these:
  - (a) instability, and/or
  - (b) symptomatic radiculopathy, and/or
  - (c) symptomatic spinal stenosis;
- (2) Disc herniation with symptomatic radiculopathy undergoing a third decompression at the same level;
- (3) Revision of pseudoarthrosis (single revision attempt);
- (4) Unstable fracture;
- (5) Dislocation;
- (6) Acute spinal cord injury (SCI) with post-traumatic instability;
- (7) Spinal infections with resultant instability;
- (8) Scoliosis with progressive pain, cardiopulmonary or neurologic symptoms, and structural deformity;
- (9) Scheuermann's kyphosis;
- (10) Tumors.

(B) Not recommended in workers' compensation patients for the following conditions:

- (1) Degenerative disc disease (DDD);
- (2) Disc herniation;
- (3) Spinal stenosis without degenerative spondylolisthesis or instability;
- (4) Nonspecific low back pain.

(C) Instability criteria: Segmental Instability (objectively demonstrable) - Excessive motion, as in isthmic or 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 15 degrees L1-2 through L3-4, 20 degrees L4-5, 25 degrees L5-S1. Spinal instability criteria includes lumbar inter-

segmental translational movement of more than 4.5 mm. (Andersson, 2000) (Luers, 2007) (Rondinelli, 2008)

(D) After failure of two discectomies on the same disc [(A)(2) above], 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.)

(E) Revision Surgery for failed previous fusion at the same disc level [(A)(3) above] if there are ongoing symptoms and functional limitations that have not responded to non-operative care; there is imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and significant functional gains are reasonably expected. 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. Workers compensation and opioid use may be associated with failure to achieve minimum clinically important difference after revision for pseudoarthrosis (Djurasovic, 2011) There is low probability of significant clinical improvement from a second revision at the same fusion level(s), and therefore multiple revision surgeries at the same level(s) are not supported.

(F) Pre-operative clinical surgical indications for spinal fusion should include all of the following:

(1) All physical medicine and manual therapy interventions are completed with documentation of reasonable patient participation with rehabilitation efforts including skilled therapy visits, and performance of home exercise program during and after formal therapy. Physical medicine and manual therapy interventions should include cognitive behavioral advice (e.g. ordinary activities are not harmful to the back, patients should remain active, etc.);

(2) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or MRI demonstrating nerve root impingement correlated with symptoms and exam findings;

(3) Spine fusion to be performed at one or two levels;

(4) Psychosocial screen with confounding issues addressed; the evaluating mental health professional should document the presence and/or absence of identified psychological barriers that are known to preclude post-operative recovery;

(5) 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)

(6) There should be documentation that the surgeon has discussed potential alternatives, b

**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)