

P&S Network, Inc.
P.O. Box 48425, Los Angeles, CA 90048
Ph: (310)423-9988 Fx: (310)423-9980

DATE OF REVIEW: August 8, 2007

IRO CASE #:

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by an orthopedist. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral posterior decompression with discectomy at L5-S1, removal of instrumentation L5-S1, L5-S1 fusion with instrumentation and intervertebral cages with one day length of stay

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

REVIEW OF RECORDS

- o Submitted medical records were reviewed in their entirety.
- o June 19, 2007 utilization review report from
- o July 10, 2007 utilization review report from
- o June 7, 2007 follow-up exam report by Dr.
- o September 6, 2006 laboratory report from Center
- o September 6, 2006 x-ray report by, M.D.
- o September 6, 2006 operative report for a bilateral L4-5 hemilaminectomy, medial facetectomy, with technical difficulty and bilateral L5-S1 medial facetectomy and foraminotomy with technical difficulty and excision of scar tissue by Dr.
- o October 17, 2006 follow-up exam report by Dr.
- o November 27, 2006 lumbar spine MRI interpreted by, M.D.
- o January 16, 2007 follow-up report by Dr.
- o March 30, 2007 x-ray report from Center
- o April 12, 2007 follow-up report by Dr.
- o May 21, 2007 letter from, M.D.
- o May 29, 2007 operative report for lumbar discography by, M.D.
- o June 18, 2007 copy of an e-mail outlining a denial to from
- o July 9, 2007 utilization review letter by, M.D.

CLINICAL HISTORY SUMMARY

The patient is a male who sustained an industrial injury on xx/xx/xx involving the lumbar spine. According to a September 6, 2006 operative report, the patient has complained of back pain with bilateral lower extremity radiculopathy since the date of injury. In August 2004, decompression at L5-S1 with posterior lumbar interbody fusion and spinal instrumentation was recommended. However, this was apparently not approved by workers' compensation and the patient was able to have surgery performed by another physician. Since that surgery, the patient has been complaining of low back pain with saddle anesthesia, numbness in both lower extremities, and erectile dysfunction with bowel and bladder dysfunction. He ambulated with a cane because he could not feel his legs. An MRI reportedly showed lateral recess stenosis at L4-5 with questionable residual stenosis at L5-S1. Surgery was again recommended.

On September 6, 2006, he underwent bilateral L4-5 hemilaminectomy, medial facetectomy, and foraminotomies with technical difficulty, as well as bilateral L5-S1 medial facetectomy and foraminotomies with technical difficulty and excision of scar tissue.

The operative report notes that there was marked fibrosis resulting in the need for removal of the fibrosis to be able to carry the dissection down. The fibrosis was very thick extending from the lumbodorsal fascia down to the dura. This posed some technical difficulty in trying to determine the plane of dissection and to determine the normal area prior to dissection into the abdominal region. There was what appeared to be an intact L3 spinous process with partial removal of the L4 spinous process. The surgeon proceeded to do a hemilaminectomy of approximately 3 to 4 mm of the lamina of L4. This was carried out laterally to do a medial facetectomy of about 15% on both sides. There was significant scar tissue and foraminotomy was extended distally, dissecting the scar tissue off of the surrounding bone. Additional removal of the disc was able to determine the S1 nerve roots and by careful dissection, additional medial facetectomy and foraminotomy together with dissection of any scar tissue was removed. Both L5 and S1 nerve roots were exposed and were freed. There was no evidence of any compression. Examination of the disc space did not show any disc bulges.

He had a follow-up visit on October 17, 2006. The patient reported that he fell in the bathtub two weeks prior and noted swelling of the operative site with increased numbness of the toes of the right foot. He was referred for a lumbar spine MRI performed on November 27, 2006 with an impression of status post L5-S1 fusion with postoperative change present posteriorly and in the right lateral recess. Within the operative region posteriorly, there was a small fluid collection noted that the radiologist stated was likely representing a small seroma or postoperative fluid pocket with infection unlikely. A left L2-3 disc herniation was also documented.

On follow-up on January 16, 2007, the patient reported continued complaints of numbness of the perineal area, both legs and the right foot. He was instructed to return in two months. X-rays were taken on March 30, 2007 with findings of transpedicular screws fusing the L5 and S1 vertebral bodies. Disc space hardware was noted at the L5-S1 level and anterior osteophytes were seen involving L2, L3, L4, and L5.

He was seen again on April 12, 2007 stating that he had persistent back pain with continued numbness of the perineum, right foot, and bowel and bladder problems with impotence. On May 29, 2007 the discogram was performed at the L4-5 level. Radial and circumferential left-sided tears of moderate severity were visualized with no full-thickness tears identified. The posterolateral aspect of the disc was found to encroach upon the foraminal area and the lateral recess area to a mild degree due to left side greater than right circumferential and radial disruptions.

On June 7, 2007 the patient again saw his physician and stated that there has been no change in bladder incontinence and the pain persists as well as numbness of the perineum radiating to both legs. The report notes that the discogram showed no concordant pain at the L4-5 level. The above captioned surgery was recommended.

A June 18, 2007 denial letter listed the reason for non-certification as the records did not reflect instability or spondylolisthesis to support fusion. The records did not reflect why the requested procedure was being requested. A peer-to-peer discussion was needed and was not performed. In addition, the Official Disability Guidelines were referenced.

A July 9, 2007 utilization review letter also rendered a non-certification because there was no documentation of instability or a psychosocial screen with confounding issues addressed.

ANALYSIS AND EXPLANATION OF DECISION

According to the medical records, there has been successful interbody fusion with posterior instrumentation at the L5-S1 level. Further decompressive surgery at that level with noted massive scar tissue and solid fusion is medically contraindicated. As noted in the Official Disability Guidelines, indications for spinal fusion may include revision surgery for failed previous operations if significant functional gains are anticipated. This patient has had a successful interbody fusion at the L5-S1 level and given the situation with massive scar tissue and solid fusion, significant functional gains are not anticipated. In the presence of massive scar tissue, it is my experience that further decompression only creates more scar tissue. Therefore, my decision is to uphold the previous non-certifications.

The IRO's decision is consistent with the following guidelines:

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

According to the Official Disability Guidelines (2007), 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: 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.