

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 04/02/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lateral discectomy and fusion with graft at L3-L4 and L4-L5

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Inpatient lateral discectomy and fusion with graft at L3-L4 and L4-L5 - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An operative report from M.D. dated 11/13/02

A CT scan of the lumbar spine interpreted by M.D. dated 05/08/03
Evaluations with M.D. dated 05/21/03, 07/14/03, 08/06/03, 02/07/05, 03/09/05, 04/07/05, 05/12/05, 05/19/05, 06/24/05, 08/14/05, 08/24/05, 10/25/05, 11/04/05, 12/05/05, 01/05/06, 03/02/06, 03/07/06, 04/20/06, 04/26/06, 07/12/06, 07/28/06, 09/27/06, 11/02/06, 05/12/07, 09/19/07, and 10/19/07
Medication lists dated 05/21/03, 03/08/04, 03/24/04, 04/05/04, 06/29/04, 08/04/04, 09/13/04, 10/04/04, 11/26/04, and 01/04/05
A procedure note from Dr. dated 07/14/03
Evaluations with P.A.-C. for Dr. dated 08/18/03, 09/18/03, 10/14/03, 11/11/03, 12/09/03, 01/09/04, 02/05/04, 04/05/04, 08/07/04, 10/04/04, and 12/06/04
Laboratory studies dated 04/05/04, 01/05/05, and 10/31/05
An evaluation with R.N. for Dr. dated 06/04/04
Evaluations with D.C. dated 01/25/05, 05/13/05, 09/13/05, 12/05/05, 02/28/06, and 07/12/06
A TWCC-53 change of treating doctor form dated 02/03/05
Applications for Disabled Person Identification dated 05/12/05, 03/22/07, and 10/19/07
A comprehensive drug screen dated 11/04/05
A patient information note dated 11/04/05
A note from Ms. dated 04/21/06
Evaluations with M.D. dated 10/15/07 and 02/18/08
A request letter from Dr. dated 10/18/07
A letter from Dr. dated 11/13/07
A health and behavioral assessment with Ed.D. dated 12/17/07
A lumbar discogram interpreted by D.O. dated 01/31/08
A post discogram CT scan interpreted by M.D. dated 01/31/08
A preauthorization request from Dr. dated 02/20/08
A letter of adverse determination, according to the ODG, from M.D. dated 02/27/08
A letter of adverse determination, according to the ODG, from M.D. dated 03/07/08
A letter from Attorneys at Law dated 03/18/08
The ODG Guidelines were provided

PATIENT CLINICAL HISTORY [SUMMARY]:

On 11/13/02, Dr. performed an arthrodesis, corpectomy, and posterolateral arthrodesis at L4-L5 and L5-S1. A CT scan of the lumbar spine interpreted by Dr. on 05/08/03 revealed some interval resorption of posterolateral graft material at L5-S1 without solid bony fusion and slight sclerotic reactive changes at the L5-S1 end plates. On 05/21/03, Dr. recommended an epidural steroid injection (ESI), a handicap sticker, Lortab, Elavil, Zyprexa, and injections of Decadron and Toradol. On 07/14/03, Dr. performed a lumbar ESI. On 10/14/03, Ms. prescribed Lortab and Elavil. On 01/09/04, Ms. prescribed Talwin NX and increased Neurontin. Laboratory studies on 04/05/04 revealed high glucose and low

hemoglobin levels. On 08/07/04, Ms. provided injections of Toradol and Decadron, along with prescriptions of Elavil and Neurontin. On 01/25/05, Dr. recommended a bariatric evaluation. On 02/07/05, Dr. prescribed Elavil, Ibuprofen, and Talwin NX. On 04/07/05, Dr. recommended a psychiatric evaluation. Laboratory studies on 10/31/05 revealed high glucose levels and 1+ occult blood in the urinalysis. On 04/26/06, Dr. discontinued Talwin and prescribed Ultracet and recommended a pain management program. On 09/27/06, Dr. again recommended a pain management program. On 09/19/07, Dr. discontinued Cymbalta, Meloxicam, and Sinequan and prescribed Lortab. On 10/15/07, Dr. recommended a lumbar discogram and psychological evaluation. On 12/17/07, Dr. recommended an interdisciplinary pain management program. A lumbar discogram interpreted by Dr. on 01/31/08 revealed severe concordant back pain at L3-L4. A post discogram CT scan interpreted by Dr. on 01/31/08 revealed mild posterior annular fissuring at L2-L3 and L3-L4. On 02/18/08, Dr. recommended further lumbar surgery. On 02/20/08, Dr. provided a preauthorization request for surgery. On 02/27/08, Dr. wrote a letter of adverse determination for the surgery. On 03/07/08, Dr. also wrote a letter of adverse determination for the surgery.

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

The patient is noted to originally have undergone an L4-L5 and L5-S1 fusion with the medical information provided indicating this patient never receiving any benefit from that fusion. Originally, a discography that had been performed revealed three levels that were bad with one good level, but only the L4-L5 and L5-S1 levels were evaluated. When the patient was seen by Dr. on 10/15/07, the patient was having ongoing back pain with no significant radicular complaints. The patient could only tolerate 10 to 15 minutes of sitting, standing, or walking. The patient had to constantly change positions. The patient had received adequate sessions of physical therapy prior to and after surgery. Recently, he had been tried on active/passive therapy with only going for a short period of time and being discharged due to lack of strength. The report by Dr. indicates the prior diagnostics being reviewed, with the CT scan from 05/08/03, revealing the previous metallic interbody fusion posterior fixation at L4-L5 and L5-S1 with stimulator device and wires at L5-S1. It was an interval resorption posterolateral graft material at L5-S1 without solid posterolateral fusion. There were x-rays reviewed that revealed the fixation devices in good position at L5-S1 and the L4-L5 area showing evidence of subsidence and some indication the interbody fusion was not intact. The lateral mass fusion appeared to be particulate, questioning the integrity. The physical examination noted extension rotation provocative going to the right; tenderness, moderate, over the hardware and exquisite over the midline. Lateral bending revealed paraspinal guarding to the right. Flexion was 45 degrees of mild to moderate discomfort and a left list. Deep tendon reflexes were equal bilaterally at the knees and ankles. The

dermatome of sensory evaluation revealed numbness in the left medial lower leg from knee to ankle, and tingling of the right great toe indicative of L4 and L5 nerve involvement. Discography was requested and performed after a psychological evaluation deemed the patient to be appropriate. The discography revealed the L3-L4 level to have severe concordant pain and the L2-L3 having no significant findings.

The rationale for approval of the surgical procedure is the patient, I feel, does meet the ODG criteria for surgical intervention with fusion in the lumbar spine as the ODG criteria for fusion is:

1. Neurologic defect: which this patient does not have.
2. Segmental instability: which the patient does not have.
3. Primary mechanical back pain with a functional spinal unit failure or instability and this patient does have primary mechanical back pain and has a spinal unit failure at L3-L4. Also, there is a strong possibility of a pseudoarthrosis at L4-L5.
4. The preoperative surgical indications include that all the pain generators be identified and treated, which the medical records indicate as having been done.
5. All physical medicine manual therapy has been completed, which is the case.
6. X-rays demonstrating spinal instability and/or myelogram, CT myelogram or discography, or an MRI demonstrating disc pathology, which the discography does demonstrate disc pathology, limited to two levels.
7. Psychosocial screening with compounding issues being addressed, which has been performed.

Therefore, at this time, the medical records contain sufficient information to support the requested inpatient lateral discectomy, fusion, and graft at L3-L4 and L4-L5, which is in line with ODG criteria.

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)