

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4/5 Interbody Fusion w/instrumentation 22630, 22842, 63005 with 5 day inpatient stay.

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity exists for L4/5 Interbody Fusion w/instrumentation 22630, 22842, 63005 with 5 day inpatient stay.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male with a reported injury on xx/xx/xx. Initial treatment records were not provided for review. Reference was made to a ruptured disc as the result of the xxxx injury with subsequent decompression. The claimant apparently had a reherniation with repeat decompression a few weeks later and subsequently went on to have nine additional spinal surgeries. The dates and reports of the surgeries were not provided; however, reference was made to an anterior lumbar interbody fusion and multiple posterior fusions and decompressions. There was reference to prior L4-5 posterior decompression and instrumentation at L5. The claimant continued to have low back and bilateral lower extremity pain and was diagnosed with failed back and chronic pain syndromes. The claimant has also treated for medical conditions including being overweight, coronary artery disease, myocardial infarction in

2000, triple bypass surgery, asthma, gastroesophageal reflux, congestive heart failure, obstructive sleep apnea with use of C-Pap, diabetes and a forty year history of smoking.

In the fall of 2008 there was notation the claimant had lost eighteen pounds and was taking Chantix. The claimant has treated with multiple medications including Hydrocodone, Cymbalta, Lyrica, Daypro, Lorazepam, Dilaudid and Clonidine. He had an implanted spinal cord stimulator and epidural Medtronic pump. The first record provided for review was an x-ray report from 04/10/08 that noted degenerative changes in the lumbar and thoracic spine with grade I spondylolisthesis at L4-5 and placement of a right spinal cord stimulator and left pain pump. CT evaluation of the lumbar and thoracic spine on 04/25/08 noted severe canal stenosis at L4-5 due to spondylosis and remote postoperative changes that resulted in complete myelographic block; broad based disc bulge; complete effacement of the subarachnoid space resulting in severe canal stenosis and block with moderate bilateral inferior foraminal narrowing without nerve root compression. Screw fixation was noted at L5, as well as bilateral facet hypertrophy and degeneration. On 04/29/08 the claimant was seen for management of the pump medications and this continued in the records provided through 11/13/08.

The claimant continued to report low back and bilateral lower extremity pain with lower extremity weakness and numbness. Dr. saw the claimant on 06/09/08 with physical examination findings of significant tenderness and spasm; positive bilateral straight leg raises; 3 + reflexes at the knees and symmetrically absent at the ankles; and decreased sensation along the bilateral L5 and S1 dermatomes. Following review of the CT study, Dr. indicated the claimant needed a decompression at L4-5 and that decompression alone at this level would likely result in further instability and worsening of the slippage and would therefore require fusion. Dr. noted the claimant would require removal of the spinal cord stimulator with subsequent MRI evaluation prior to surgical intervention. On 07/01/08 it was noted the claimant passed his cardiac stress test and was requiring six Hydrocodone a day for breakthrough pain. On 07/29/08 Dr. reported the claimant was having some problems with urinary hesitancy. The claimant underwent explantation of the spinal cord stimulator via laminectomy and explantation of the pulse generator on 09/16/08.

Thoracic and lumbar MRI evaluation on 09/17/08 noted severe degenerative changes at L4-5 resulting in severe canal stenosis and complete block with height loss, endplate edema, prior posterior decompression, narrowing thecal sac, moderate right foraminal narrowing, mild left foraminal narrowing and complete block with clumping and enhancement of the nerve roots. Dr. continued to recommend L4-5 decompression and fusion. On 10/14/08 physical examination noted 1+ edema in the lower legs, blunted sensation in the bilateral lower extremities and impaired strength due to pain. A letter from Dr. on 11/10/08 indicated that failure to have the proposed surgery would likely lead to permanent neurologic deficits. On 11/13/08 the treating nurse practitioner noted gait instability with more frequent falls, decreased balance and weakness. Surgical intervention with L4-5 interbody fusion and instrumentation, as well as a five day length of stay continues to be recommended.

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

The claimant has gait instability with severe stenosis at L4-5 that would warrant a decompression. The spondylolisthesis would also justify a fusion. The claimant has failed conservative measures. Thus the proposed fusion would be appropriate and recommended as medically necessary. The reviewer finds that medical necessity exists for L4/5 Interbody Fusion w/instrumentation 22630, 22842, 63005 with 5 day inpatient stay.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Low Back-Fusion

Milliman Care Guidelines, Twelfth Edition; Lumbar- Fusion

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)