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Notice of Independent Review Decision

DATE OF REVIEW: April 8, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
L2-L3 hardware removal, fusion, exploration, and decompression at L3-L4

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

REVIEW OUTCOME

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

☒ Overturned (Disagree)

Medical documentation **supports the medical necessity** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (02/06/09 – 03/04/09)

- Utilization reviews (02/06/09 – 03/04/09)
- Operative notes (01/30/08)
- Diagnostics (12/16/08)
- Office visits (01/27/09 – 03/11/09)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who was injured on xx/xx/xx while working . He sustained a low back injury while pushing and tugging to break a well head bolt.

In xx/xxxx, the patient was diagnosed with small disc protrusion at L2-L3 and L4-L5 and had extensive conservative treatment for ongoing back pain and bilateral groin pain, left greater than right, and occasional numbness in the right leg. Examination revealed marked mechanical findings with decreased flexion and extension. Extension reproduced the groin pain. Magnetic resonance imaging

(MRI) and plain x-rays revealed gross instability of L2-L3 with about 1-cm retrolisthesis and partially corrected inflection, slight bulge at L4-L5 with some diffuse narrowing as well as some foraminal narrowing at L2-L3.

On January 30, 2008, M.D., performed subtotal laminectomy and total facetectomy at L2-L3 bilaterally, subtotal laminectomy at L3 bilaterally, decompression with foraminotomies at L2-L3 nerve roots bilaterally, discectomy at L2-L3 on left, transforaminal interbody fusion L2-L3 left with local autograft bone, spinal instrumentation at L2-L3 bilaterally, and posterolateral fusion at L2-L3 bilaterally with local autograft bone plus bone morphogenic protein. The postoperative diagnosis was L2-L3 instability with recess stenosis.

In December 2008, MRI of the lumbar spine demonstrated postsurgical lumbar spine with an anterior interbody fusion at L2-L3, mild-to-moderate L4-L5 central spinal canal stenosis and intervertebral neural canal stenosis secondary to disc bulging and associated soft tissue and bony changes, mild stenosis at L1-L2 and L3-L4 secondary to mild disc bulging and associated soft tissue and bone changes, and mild arthritis. X-rays revealed postsurgical lumbar spine with L2-L3 anterior interbody fusion, mild L2-L3 and L3-L4 retrolisthesis, thoracic and lumbar spondylosis, and arthritis.

On January 27, 2009, Dr. noted some diffuse tenderness just to the right and left of the midline of lumbar region, restricted forward flexion secondary to pain. The patient had terminal extensor lag while he returned to upright posture and also had an increasing amount of back pain. Thoracic MRI scan showed a right-sided disc protrusion at T6-T7. Dr. assessed L2, L3, and L4 instability with probable pseudoarthrosis; instability at L3-L4; and lumbar spondylosis. He stated the patient was doing better until about three to four months ago when he began experiencing increasing amount of back pain. He had some episodes with right leg wanting to give way. The patient had been seeing Dr. for pain management, but was unable to manage the increasing pain. He was taking Norco and Neurontin. Dr. recommended another surgical procedure consisting of decompression, fusion, and spinal instrumentation; however, he was concerned that the patient was a smoker; he smoked one-and-a-half pack of cigarettes a day. He advised the patient to stop smoking completely before proceeding with the surgery.

On February 6, 2009, M.D., denied the request for L2-L3 hardware removal, fusion, exploration, decompression at L3-L4 with the following rationale: *The patient has not, at this point in time, confirmed that he has quit smoking. Because that is such an important factor and likely had a role in the development of this patient's spondylolisthesis, until he has confirmed his recommendations are being adhered to, the patient had quit smoking, the surgical request can neither be considered reasonable nor medically necessary. The patient is likely to come to surgery whether or not he quit smoking, but based on history of pseudoarthrosis and in the absence of compelling indications such as progressive neurologic deficit, it is reasonable to make every effort to have this patient quit smoking to optimize his chances for solid fusion based on his history of pseudoarthrosis at his previous surgical level. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, the request for L2-L3 hardware removal fusion exploration, decompression, L3-L4 is not recommended.*

On March 4, 2009, M.D., denied the appeal for L2-L3 hardware removal fusion exploration, decompressive L3-L4 with the following rationale: *For any potential surgery, it is recommended that the patient refrain from smoking for at least six weeks prior to the surgery until the period of fusion healing. The clinician does not meet current guidelines criteria for this procedure. The patient has a history of a two pack a day smoking history, and records do not reflect that the patient had stopped. After discussing with Dr. it is obvious that the patient had instability as well as a frank pseudoarthrosis; however, evidently the patient is unable to stop smoking, which still puts him at high risk for nonunion. This does not meet guideline criteria. With this information, the request is not certified. Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines, the request for L2-L3 hardware removal fusion exploration, decompression L3-L4 is not medically necessary.*

On March 11, 2009, x-rays of the lumbar spine showed lucencies around the interbody fusion at L2-L3 and L3-L4. There was retrolisthesis about 9-10 mm which partially corrected in the flexion. Dr. assessed pseudoarthrosis at L2-L3 fusion and lumbar instability at L3-L4. The patient stated that he had been able to cut back to three to four cigarettes a day and had been doing this since his last office visit. Dr. felt that at that rate it should not adversely affect his fusion. Currently his back problem was related to the pseudoarthrosis at L2-L3 and significant instability at L3-L4 with almost a 1-cm retrolisthesis that corrected about 6 mm in flexion. Dr. Denno submitted for the proposed lumbar surgery. The patient remained disabled.

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

Medical material reviewed included:

1. Patient clinical history in the form of a summary provided by Matutech, Inc.
2. 1/30/2008 operative report regarding lumbar spine surgery by M.D.
3. 12/16/2008 lumbar spine MRI with and without enhancement report
4. 12/16/2008 report of x-rays of the lumbar spine with flexion and extension views
5. 1/28/2009 report by M.D.
6. Insurance Company utilization review reports of 2/6/2009 and 3/4/2009
7. Spine Clinic report of 3/11/2009
8. ODG TWC Integrated treatment disability duration guidelines

This case involves that of a male who on xx/xx/xx was pushing a well head bolt and developed low back pain with bilateral groin pain and numbness in his right lower extremity. Conservative management was unsuccessful and an MRI of the lumbar spine showed L2-3 instability with retrolisthesis and on 1/20/2008 and L2-3 posterior lumbar fusion with laminectomy and posterior lateral fusion was carried out. The patient did well for several months but about three or four months ago developed recurrent back pain. Repeat MRIs on 12/16/2008 and 1/29/2009 suggests instability at the L2-4 level and this was supported by plain flexion and extension views of the spine

also. In addition, there was trouble with pseudoarthrosis and the patient's general examination suggested that the hardware previously placed may be a problem may be a problem in regard to local tenderness and pain in his lumbar spine region.

I disagree with the denial for the proposed operative procedure of instrumentation removal and fusion at the L3-4 level. There is adequate imagining study evidence of difficulty great enough at the L3-4 level to be causing his difficulty. In addition, his general examination of his back suggested that hardware may be also a problem. Therefore the removal of that hardware which will probably be replaced by hardware at the level below his previous fusion is thought also indicated. The amount of smoking that the patient does has markedly diminished and that should not be a problem regarding the fusion. Waiting with more conservative measures such as bracing would probably not change the eventual necessity for the surgery.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

In regards to ODG guidelines, these were not used. The use of guidelines has become more and more of a potential problem as reported in several articles primarily because they frequently do not apply to individual cases. These guidelines were not used in this report.

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

My experience of 40 years of dealing with these troubles is my means of coming to the above conclusions.