

US Decisions, Inc.

An Independent Review Organization

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DATE OF REVIEW: FEBRUARY 16, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Decompression & stabilization fixation L3-4/L4-5 and LOS 2-4 Days

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 does not exist for Decompression & stabilization fixation L3-4/L4-5 and LOS 2-4 Days.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 1/20/09, 12/19/08
ODG Guidelines and Treatment Guidelines
MRI, 5/24/04
EMG/NCS, 7/7/04, 07/23/07, 10/27/08
Myelogram, 9/13/04
Lumbar discogram, 12/22/05
OR reports, 12/11/06, 02/14/06, 07/30/08, 08/06/08
Office note, Dr., 01/10/07, 12/11/08
Office note, Dr., 7/10/07, 09/18/08, 10/16/08
CT lumbar spine, 9/24/07
CT lumbar spine, 04/29/08
CT abdomen/pelvis, 8/5/08

MRI lumbar spine, 10/02/08
X-rays, Dr., 10/16/08
Trigger point injection, 10/16/08
Peer review, Dr., 10/24/08
Office note, Dr., 11/13/08
Request for reconsideration, Dr., 1/12/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a xx-year injured on xx/xx/xx and diagnosed with lumbar strain. On 12/11/06, he underwent decompressive laminectomies and discectomy at L2-3, L3-4, and L4-5 on the right. The claimant had a history of smoking and coronary artery disease. He continued with back and bilateral leg pain, right greater than left. On 07/30/08, he underwent L1-2 and L2-3 decompressive laminotomy, foraminotomy, discectomy and facetectomy with pedicle fixation at L1, L2 and L3 bilaterally. Subsequently on 08/06/08, he had exploration and drainage of a hematoma.

The records indicated that the claimant had some return of motor function but sensation and strength remained decreased in both lower extremities with reports of urinary incontinence. A 10/02/08 MRI of the lumbar spine with contrast showed T12-L1 moderate loss of disc space height with apparent fusion at L1-2. There was a pseudomeningocele in the laminectomy defect measuring 3.1x1.4 centimeters that ran from L1-2 to L2-3 and enhancing scar around the thecal sac and nerve roots. There was L2-3 moderate loss of disc space height with the hardware in place, no significant neural foraminal narrowing, and enhancing scar noted around the thecal sac and nerve roots as well as the laminectomy defect. At L3-4, there was moderate to severe loss of disc space height; disc protrusion/extrusion; ligamentum flavum hypertrophy and facet hypertrophy with right lateral recess stenosis; enhancing scar was seen around the right thecal sac and right nerve root. There was L4-5 moderate loss of disc space height, minimal retrolisthesis; protrusion/extrusion along with ligamentum flavum and facet hypertrophy caused lateral recess stenosis bilaterally and there was mild right neural foraminal narrowing.

An office note by Dr. on 10/16/08 noted continued pain with bowel and bladder incontinence reported. The claimant continued with a bone growth stimulator and a urology consult was ordered. Trigger point injections on the left and right lumbosacral region provided some relief.

Electrodiagnostic studies on 10/27/08 noted significant pain limitation with acute irritability L3 through S1 motor roots, possibly involving L2 and complete absence of external anal sphincter firing.

On 12/11/08, Dr. saw the claimant for constant back and left leg pain with numbness and tingling. He used a walker and a brace. The claimant was also noted to be incontinent of bowel and bladder. He used a bone growth stimulator, was in therapy and had an epidural steroid injection. Medications included Lyrica and Hydrocodone. On examination, there was spasm and pain on palpation of the hips. There was an absent right patella reflex and Achilles reflexes bilaterally. Straight leg raise was positive bilaterally for back and leg pain. Right lower extremity strength was 3+/5 and left 4/5. He had hyperesthesia of the posterior right lower leg and the right foot and left foot. The impression was L3, 4, 5 and S1 radiculopathy; herniation at L3-4 and 4-5, incontinence and central and foraminal stenosis L3-4 and 4-5 on MRI. Dr. noted the MRI on 10/02/08

showed central and foraminal stenosis at L3-4 and L4-5 with disc herniation at both levels. Decompression and stabilization fixation L3-4/L4-5 and length of stay two to four days was recommended.

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

Lumbar spine fusion is not medically indicated in this particular case, as there is no documentation or evidence of instability, tumor, or infection. There is also no documentation of a progressive neurologic deficit to warrant surgical intervention. Therefore, based upon the medical records provided for review the request for the proposed surgery does not meet the ODG Guidelines and cannot be recommended as medically necessary. The reviewer finds that medical necessity does not exist for Decompression & stabilization fixation L3-4/L4-5 and LOS 2-4 Days.

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
- AHCPH- 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)