TMF
Health Quality Institute

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Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 07/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L5-S1 Revision/Decompression/Exploration & Repair with a 2 day LOS

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the L5-S1 Revision/Decompression/Exploration & Repair with a 2 day LOS is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 07/13/09
- Notification of Determination from – 05/15/09, 06/24/09, 07/09/09
- Notice of Independent Review Decision by – 01/30/09
- Office Visit notes from Dr. – 02/27/07 to 04/14/09

- Report of MRI, CT scan, Myelogram Review – 04/13/09
- Report of lumbar myelogram/post-myelogram CT scan – 04/01/09
- Report of the MRI of the lumbar spine – 05/26/05, 04/24/08, 12/12/08
- Operative report by Dr – 02/27/07 to 05/13/08
- Report of CT scan of the lumbar spine – 04/14/04, 05/26/05, 03/29/06, 03/28/07
- Consultation by Dr. – 11/04/08
- Office visit notes by Dr. – 01/06/09 to 06/30/09
- Office visit notes by Dr. – 01/06/09 – 02/06/09
- Carrier Submission from Law Offices – 07/16/09
- Office visit notes from Dr. – 04/26/04 to 05/24/04
- Physical therapy evaluation and treatment by – 06/01/04 to 08/18/04
- Medical Report by Dr. – 09/01/04
- Independent Medical Evaluation Report by Dr. – 12/01/04
- Portions of a medical record from for admission – 04/21/05, 07/28/05, 11/26/05
- Orthopedic Consultation by Dr. – 05/16/05
- Letter from Dr. – 07/18/05
- Office visit notes by Dr. – 07/19/05, 05/03/06
- Laboratory values – 07/21/05
- Report of chest x-ray – 07/19/05
- Operative Report by Dr. – 07/28/05, 05/11/06
- X-ray report of lumbar spine – 08/12/05, 10/19/06
- Office visit notes by Dr. – 06/27/05 to 04/10/06
- Physical therapy notes 10/17/05 to 11/15/05
- Report of nerve conduction study – 05/11/06
- Initial chiropractic evaluation – 09/12/06
- Office visit notes by Dr. – 08/13/06 to 05/03/07
- Office visit not by – 09/11/06 to 04/09/09
- Physical Performance Evaluation by Dr. – 11/08/06
- Functional Capacity Evaluation – 10/06/06, 12/18/06, 01/30/07, 0915/08
- Subsequent Evaluation by Dr. – 10/18/06 to 04/23/09
- Physical Performance Evaluation by Dr. – 12/18/06 to 01/30/07
- Behavioral Health Assessment – 01/30/07, 09/19/08
- History and Physical by Dr. – 04/27/07
- Clarification of RME by Dr – 05/17/07
- A portion of the medical record from for admission – 12/12/07
- Retrospective Peer Review Report by Dr. – 05/13/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related straining injury to the lumbar spine on xx/xx/xx

when she was lifting a case of canned apple sauce. She was initially treated for low back pain with medications, chiropractic therapy, epidural steroid injections and activity modification. An MRI scan performed on 05/08/02 revealed degenerative disc disease at L4-L5 and spondylolisthesis at L5-S1. A facet fusion surgery was performed on 04/13/04 at L4-L5 and L5-S1. On 07/28/05 a decompression surgery was performed. The patient's symptoms of back pain and leg pain persisted. An anterior interbody fusion a L4-L5 and L5-S1 was performed. Revision surgery was performed on 12/12/07 involving L3-S1. Symptoms of "failed back syndrome" persisted. A trial of spinal cord stimulator was recommended. An MRI performed on 12/12/08 revealed changes compatible with the four prior surgeries. Additionally, a change in the extent of spondylolisthesis between L5-S1 was documented with change of position from recumbent to standing. Leg pain is increasing. Progressive motor weakness was documented. Fracture of the fusion mass with pseudarthrosis at L5-S1 was documented. The patient has received a recommendation for L5-S1 revision/decompression/exploration/repair – 2 day LOS. The request for pre-authorization has been denied; reconsidered and denied. A myelogram performed 04/01/09 revealed solid fusion at L4-S1. No abnormal motion was recognized with flexion and extension; however, the CT following the myelogram revealed pseudarthrosis thru the posteriolateral fusion mass. The anterior interbody fusion has not incorporated at the L5 endplate.

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

The volume of information provided for review is relevant to the recognition that this patient suffers a "failed back syndrome". It does appear that this patient suffers "failed back syndrome". She has undergone a number of surgical procedures and suffers persistent painful symptoms. It also appears that she is suffering progressive neurological deficits. There are conflicting reports of imaging studies. The presence of a pseudarthrosis at the level of L5-S1 is suggested but not consistently documented. It is not clear whether or not she is suffering instability at this level. Multiple levels of degenerative disc disease are documented.

The multiple levels of degenerative disc disease suggest multiple pain generators. The extent of the contribution to pain by the various levels of degenerative disc disease has not been documented. Clearly more that 2 levels are involved. No psychosocial evaluation is present. Instability has not been clearly demonstrated. The likelihood of achieving a good or acceptable result after yet another spine surgery is very limited. The criteria published in the ODG 2009, Low back chapter have not been met.

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)