

Notice of Independent Review Decision

DATE OF REVIEW: 3/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior lumbar interbody fusion at L4-S1; posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L5-S1

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Neurosurgery at. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Neurosurgery since 11/13/1992 and currently resides in .

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Anterior lumbar interbody fusion at L4-S1; posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L5-S1 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. IRO request dated 3/4/2009
2. Request for a review dated 3/2/2009
3. Clinical note dated 1/22/2009
4. Clinical note dated 2/16/2009
5. Notice dated 3/5/2009
6. Clinical note dated unknown
7. Notice of assignment dated 3/5/2009
8. Cover sheet dated 3/5/2009
9. Clinical note by MD, dated 6/6/2007
10. Consultation dated 2/25/2008
11. Procedure note by DO, dated 3/6/2008
12. Clinical note dated 5/31/2007
13. Preliminary report dated 7/17/2006
14. Initial chart note by MD, dated 1/22/2007
15. Procedure report by DO, dated 12/20/2006
16. Initial pain evaluation by DO, dated 12/6/2006
17. Initial pain evaluation by DO, dated 12/6/2006
18. Observation by MD, dated 10/25/2006
19. Operative report dated 6/6/2007
20. Request for a review dated 3/2/2009
21. Clinical note by MD, dated 2/26/2009
22. Authorization request dated 2/9/2009
23. Clinical note dated 1/22/2009 to 2/18/2009
24. Authorization request dated 2/9/2009
25. Evaluation by LPC, dated 1/19/2009
26. CT of the lumbar by MD, dated 10/25/2006

Name: Patient_Name

27. Lumbosacral spine by MD, dated 2/21/2009
28. MRI of the lumbar spine by MD, dated 1/7/2009
29. Lumbosacral spine by MD, dated 1/14/2009
30. Appeal letter dated 2/9/2009
31. Clinical note by MD, dated 6/15/2007 to 1/13/2009
32. Operative report dated 6/8/2007
33. Notice to utilization dated 3/5/2009
34. Confirmation of receipt dated 3/4/2009
35. IRO request form dated unknown
36. Request for a review dated 3/2/2009
37. Clinical note dated 1/22/2009 to 2/16/2009
38. Authorization request dated 2/9/2009
39. Appeal letter dated 2/9/2009
40. Clinical note by MD, dated 6/15/2007 to 1/13/2009
41. Lumbosacral spine by MD, dated 1/14/2009
42. MRI of the lumbar spine by MD, dated 1/7/2009
43. Operative report by MD, dated 6/5/2007
44. Consultation dated 2/25/2008
45. Procedure note dated 3/6/2008
46. Authorization request dated 1/19/2009
47. Clinical note by MD, dated 6/15/2007 to 1/13/2009
48. MRI of the lumbar spine by MD, dated 1/7/2009
49. Operative report by MD, dated 6/5/2007
50. Clinical note dated 6/31/2007
51. Clinical note dated 6/18/2007
52. Clinical note by MD, dated 2/26/2009
53. Evaluation by LPC, dated 1/19/2009
54. CT of the lumbar spine by MD, dated 10/25/2006
55. Lumbosacral spine by MD, dated 2/21/2009
56. MRI of the lumbar spine by MD, dated 1/7/2009
57. Operative report by MD, dated 8/6/2007
58. Consultation dated 2/25/2008
59. Procedure note dated 3/6/2008
60. Clinical note dated 5/31/2007
61. Preliminary report dated 7/17/2006
62. Procedure report by DO, dated 12/20/2006
63. Procedure report by DO, dated 12/20/2006
64. Initial pain evaluation by DO, dated 12/5/2006 and 12/6/2006
65. Observation by MD, dated 10/25/2006
66. Operative report by MD, dated unknown
67. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who suffered a work-related injury to his low back on xx/xx/xx. He was diagnosed with lumbar radiculopathy and a HNP at L5-S1. He was taken to surgery on 8/8/2007 where he underwent a lumbar microdiscectomy, laminectomy, foraminotomy, and a partial facetectomy at L5-S1 on the left. The injured employee denied any left lower extremity pain on a follow-up visit on 6/15/2007. He did, however, describe intermittent numbness and tingling in a non-dermatomal distribution of the left lower extremity and peri-incisional muscle spasms.

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

In January 2008 the claimant had complaints of left leg pain and subsequently underwent an epidural steroid injection in March 2008. In July 2008 he again had complaints of left leg pain. An MRI done in January 2009 revealed a recurrent disc herniation on the left at L5-S1, mild bulges at L3-4 and L4-5 and a left L2-3 foraminal protrusion. The claimant had x-rays in February 2009 which revealed a 4mm spondylolisthesis at L4-5.

The claimant may be symptomatic from the recurrent disc herniation on the left at L5-S1 and therefore may be a candidate for a laminotomy and discectomy at L5-S1.

Per ODG-Surgical discectomy for carefully selected patients with radiculopathy due to lumbar disc prolapse provides faster relief from the acute attack than conservative management. (Gibson-Cochrane, 2000) (Malter, 1996) (Stevens, 1997) (Stevenson, 1995) (BlueCross BlueShield, 2002) (Buttermann, 2004).

The claimant is not a candidate for an anterior or posterior fusion at L5-S1. There is no evidence of instability (such as a spondylolisthesis, fracture etc.) at L5-S1 to warrant a fusion. Furthermore, there is no documentation in

Name: Patient_Name

the record of progressive neurologic dysfunction. The claimant had mild longstanding documented deficits which remain unchanged.

Per ODG-Spinal fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis, or frank neurogenic compromise.

There is no evidence that the claimant is symptomatic from the spondylolisthesis at the L4-5 level therefore there is no indication for an anterior interbody fusion at the L4-5 level.

At this time, the request is considered not medically necessary in accordance with the ODG guidelines. Therefore, the previous denial is upheld.

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
X 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)