



DATE OF REVIEW: 12/09/10

IRO Case #:

Description of the services in dispute:

Anterior lumbar interbody fusion at L4/5, decompression at L4/5 on the far lateral left, lumbar laminectomy/diskectomy L5/S1 with foraminotomy on the left, 3 days inpatient stay (#22558, #63090, #22851, #22845, #63047, #63048, #63030, #63035).

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is a fellow of the American Board of Orthopaedic Surgery. This reviewer is a fellow of the North American Spine Society and the American Academy of Orthopaedic Surgeons. This reviewer has been in active practice since 1990.

Review Outcome

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

Upheld

Anterior lumbar interbody fusion at L4/5, decompression at L4/5 on the far lateral left, lumbar laminectomy/diskectomy L5/S1 with foraminotomy on the left, 3 days inpatient stay (#22558, #63090, #22851, #22845, #63047, #63048, #63030, #63035) is not medically necessary.

Information provided to the IRO for review

Records from the State:

Request for review by and independent organization, 11/19/10, 5 pages

Request Form, 11/18/10, 3 pages

Preauthorization Determination, 10/05/10, 3 pages

Preauthorization Determination, 11/08/10, 3 pages

Records received from:

Texas Department of Insurance notice to utilization review agent of assignment of independent review organization letter, 11/22/10, 2 pages

Prior Review by Dr. MD, 10/14/10, 2 pages

Preauthorization Determination, 11/08/10, 3 pages

Orthopedic Associates Fax Cover Sheet, 9/28/10, 1 page

Health Centers presurgical screening evaluation, 7/22/10, 4 pages

DO, office visit, 8/27/10, 1 page

DO, office visit, 7/07/10, 1 page

DO, office visit, 6/30/10, 1 page
MD, clarification of note on 6/29/10, 7/06/10, 1 page
MD, initial consultation, 6/29/10, 3 pages
e-mail correspondence, 10/05/10, 1 page
DO, office visit, 5/25/10, 1 page
DO, office visit, 4/27/10, 1 page
DO, office visit, 4/21/10, 1 page
DO, office visit, 3/17/10, 1 page
DO, office visit, 2/23/10, 1 page
DO, office visit, 2/17/10, 1 page
MD, electrodiagnostic studies, 3/11/10, 5 pages
Hospital MRI of lumbar spine without contrast, 2/18/10, 3 pages
Rehabilitation, Inc. physical therapy prescription, 3/22/10, 1 page
Rehabilitation, Inc. functional capacity evaluation, 3/16/10, 9 pages
Hospital operative report, 2/19/10, 2 pages
Hospital history and physical, 2/17/10, 2 pages

Patient clinical history [summary]

The patient is female who sustained an injury to the low back on xx/xx/xx while trying to maneuver a cart through slush and light snow. The patient is status post L3-4 instrumentation "in the past" and L4-5 laminectomy, medial facetectomy, and lumbar laminectomy with foraminotomy at L5 on 2/16/09. The patient saw Dr. on 2/17/10. The patient rates her pain at 0 out of 10 on the visual analogue scale (VAS) scale. The patient reports a sensation of pressure in the low back, as well as numbness and spasm in the left lower extremity. The patient denies bowel or bladder dysfunction. Current medications include Prozac, Humulin, Adderall, Protonix, Nicotin Patch, Zanaflex, Lovenox, trazodone, Phenergan, lorazepam, and Demerol PCA. The patient has smoked a pack a day for 25 years. The physical exam reveals the patient ambulates with a slow, antalgic gait. The physical exam reveals a 10 cm lumbosacral midline scar and bilateral sacral scars. There is tenderness in the lower third of the midline scar. Lumbosacral range of motion is severely limited. Straight leg raise to 75 degrees on the left causes pressure in the low back. The patient is assessed with lumbar spondylosis and left lumbar radiculitis. The patient is recommended for a left transforaminal epidural steroid injection and caudal epidural steroid injection. The patient is prescribed gabapentin. The MRI of the lumbar spine performed 2/18/10 demonstrates multiple postoperative and degenerative changes. There are bilateral pedicle screws at the L3 and L4 levels. Mild narrowing and signal loss of the disc at L4-5 is noted along with moderate diffuse disc bulging. There are facet joint degenerative changes at L5-S1 on the left, including facet joint capsule and ligament hypertrophy mildly impressing the left side of the thecal sac. Moderate foraminal narrowing at L5-S1 is noted. The patient underwent a caudal epidural steroid injection and a left L5-S1 transforaminal epidural steroid injection on 2/19/10. The electrodiagnostic studies performed on 3/11/10 reveal electrical evidence of remote left L5 radiculopathy. There is clinical and electrical evidence of peripheral polyneuropathy. There is no electrical evidence of active or acute lumbar/lumbosacral

radiculopathy bilaterally. A functional capacity evaluation is performed on 3/16/10. The patient is functioning at a medium physical demand level. The patient demonstrates the ability to perform the tasks of her job and shows the ability to return to full duty without modifications. The patient saw Dr. on 3/17/10. The physical exam reveals positive tension signs. There is good motor strength in all major muscle groups. The patient is assessed with left L5 radiculopathy. The patient is recommended for acupuncture. The patient saw Dr. on 4/27/10. The patient continues to have severe pain down the left leg in an L5 dermatome. The physical exam reveals positive straight leg raise. There is extensor hallucis longus weakness and anterior tibialis weakness on the left. The note states the patient has failed physical therapy and epidural steroid injections. The patient is recommended for surgical intervention with the possibility of inserting an X-STOP distracter.

The patient saw Dr. on 7/07/10 with complaints of severe left leg pain. The physical exam reveals tension signs on the left. There is some anterior tibialis weakness on the left and some quad weakness on the left. Radiographs of the lumbar spine demonstrate marked instability at L4-5 with an extremely increased angle and some lithiasis noted. This report is not provided for review. The patient is recommended for an anterior lumbar interbody fusion at L4-5 with decompression at L4-5 on the far lateral left and lumbar laminectomy discectomy at L5-S1 with foraminotomy on the left. The patient is seen for pre-surgical screening evaluation on 7/22/10. The patient complains of numbness, muscle spasm, and a foot drop. The patient also reports bowel and bladder dysfunction. The patient previously tried epidural injections with only temporary relief. The patient is not a candidate for physical therapy because her pain worsens with exercise. Current medications include Prozac, Humulin, Adderall, Protonix, trazodone, Phenergan, Demerol PCA, hydrocodone, and Lidoderm Patches. The patient states she has been off of work for the past two weeks due to her injury. The pain worsens with sitting, driving, walking, or maintaining any posture for a prolonged period of time. The patient reports feelings of depression and anxiety, but feels her current medications adequately control her symptoms. The patient hopes to reduce her pain and symptomology to a tolerable level that enables her to work, spend time with family, and resume leisure activities. The patient states she will strictly follow the doctor's recommendations for a successful outcome. The patient is felt to be an appropriate candidate for surgical intervention.

The patient saw Dr. on 8/27/10. Dr. is unsure why the patient's surgery would be denied due to her being a diabetic and history of smoking. The note states the patient underwent a fusion years ago and "fused beautifully", despite being a diabetic and smoker. The physical exam reveals positive straight leg raise and positive tension signs. There is a decreased posterior tibialis tendon reflex. The request for lumbar fusion of L4-5 and decompression of L4-5 and L5-S1 is denied by utilization review on 10/05/10 due to no documentation of instability. The patient is a smoker. The patient has a history of depression and anxiety, and there is no evidence that a pre-operative psychological screening has been performed. The request for lumbar fusion of L4-5 and decompression of L4-5 and L5-S1 is denied by utilization review on 11/08/10 due to no acute electrodiagnostic findings. The patient is a long-term smoker, and there are no confirmation laboratory studies to show that she has discontinued smoking. There is no documentation of instability.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

Based on the clinical documentation provided for review, the prior denials should be upheld. The clinical documentation provided for review does not support the requested surgery and 3 day inpatient stay and does not meet guideline recommendations for the procedure. The imaging studies provided for review do reveal evidence of moderate foraminal narrowing at L5-S1 and mild spondylosis at L4-5; however, no significant degenerative disc disease, spondylolisthesis, or motion segment instability is noted at L4-5 that would reasonably require the requested fusion procedures. There is no documentation regarding a psychological evaluation addressing any possible confounding issues and would be recommended given the patient depression symptoms. The patient has a long history of smoking and guidelines recommend that patient's discontinue smoking prior to any fusion procedures. As the clinical documentation does not meet guideline recommendations for the request, medical necessity is not established.

A description and the source of the screening criteria or other clinical basis used to make the decision:

1. Official Disability Guidelines, Online Version, Low Back Chapter.