

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 11/23/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 day length of stay (LOS)
discectomy
lumbar laminectomy
arthrodesis with cages
posterior instrumentation at the L5-S1 level

QUALIFICATIONS OF THE REVIEWER:

Orthopaedics, Surgery Trauma

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)

2 day length of stay (LOS) Upheld
discectomy Upheld
lumbar laminectomy Upheld
arthrodesis with cages Upheld
posterior instrumentation at the L5-S1 level Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Facsimile cover sheet by dated 11/12/2010
2. Letter by dated 11/10/2010
3. Notice of utilization review finding by dated 10/29/2010-11/2/2010 multiple dates
4. Lumbar spine series 6 views by MD dated 10/5/2010
5. Evaluation note by DC dated 9/15/2010
6. Office visit by MD dated 8/17/2010-10/19/2010 multiple dates
7. Letter by MD dated 8/17/2010
8. Evaluation note by MA, LPC dated 7/16/2010
9. New patient surgical consultation by, MD dated 4/20/2010
10. MRI scan review by MD dated 4/19/2010
11. Evaluation note by, DC dated 3/25/2010
12. Follow-up note by PAC dated 3/25/2010
13. Procedure note by MD dated 3/3/2010
14. MR lumbar spine by, MD, FACC dated 12/15/2009
15. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male injured with back pain. He injured his back on xx/xx/xx when struck by a. He was treated with medications, restricted duty, physical therapy (PT) and epidural steroid injection (ESI). A 12/15/09

Name: Patient_Name

magnetic resonance imaging (MRI) demonstrated a diffuse disc bulge at L3-4 without herniation or narrowing. A behavioral health exam was completed 5/14/10 indicating a recommendation for individual psychotherapy. He had electromyography/nerve conduction velocity (EMG/NCV) conducted 6/24 and 7/7/10. There were normal evoked potentials, minor nerve root changes at L5-S1, but not correlating with anterior thigh paresthesia complaints. He has had multiple radiographs, including flexion and extension films. Dr. interpreted the 4/10 flexion/extension films to demonstrate 6.5 mm of motion. Repeat flexion/extension films were interpreted as lack of support at L5-S1 with spinal motion and collapse 5 mm and posterior facet hypertrophy and subluxation. The latest clinical exam note by Dr. indicates positive Spring test L5-S1, positive Flip test bilateral, positive Lasègue's at 45 degrees, decreased ankle jerk, posterior tibial reflex, weakness in the gastrocnemius/soleus and paresthesias in L5-S1.

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

There are several reasons for the upholding the previous denial of the 2 day length of stay (LOS), discectomy, lumbar laminectomy, arthrodesis with cages, and posterior instrumentation at the L5-S1 level:

There is no encroachment of nerve root on MRI; discordance between MRI and clinical exam; no true radiculopathy noted per nerve root levels on MRI; no evidence of instability warranting a fusion on official radiographic, independent interpretation; there is discordance between EMG findings, clinical complaints and MRI and lastly, there has been no psychological exam completed. The upholding of the denial falls within The Official Disability Guidelines (ODG) criteria.

Radiculopathy:

L3 sciatica: L2/L3 disc; L3 root supplies sensation to the front and side of the thigh, as the lateral femoral cutaneous nerve. The lumbar disc which would typically affect this nerve is the L2/L3 disc centrally, or the L3/L4 disc laterally in the neural foramen.

L4 sciatica: L3/L4 disc: L4 root supplies sensation to the anterior lower thigh. The lumbar disc which would typically affect this nerve is the L3/L4 disc centrally, or the L4/L5 disc laterally in the neural foramen.

L5 sciatica: L4/L5 disc: L5 root supplies sensation to the top of the foot and the great toe. The lumbar disc which would typically affect this nerve is the L4/L5 disc centrally, or the L5/S1 disc laterally in the neural foramen.

S1 sciatica: L5/S1 disc: S1 root supplies sensation to the outside of the foot, and the small toe. The lumbar disc which would typically affect this nerve is the L5/S1 centrally. There is no S1/S2 disc to herniate laterally to affect it.

ODG criteria indicate for lumbar fusion in workers' comp patients: In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study."

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following:

(1) All pain generators are identified and treated;

This injured employee has pain generators involving multiple levels.

(2) All physical medicine and manual therapy interventions are completed

Some intervention was documented.

(3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology;

Official interpretation does not demonstrate instability.

(4) Spine pathology limited to two levels;

There is pathology at 2 non contiguous levels.

(5) Psychosocial screen with confounding issues addressed

This is not documented and the injured employee was recommended for IBT

(6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

None of these were mentioned in the records reviewed. The recommendation is to uphold the previous denial.

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

Name: Patient_Name

- 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)