

SENT VIA EMAIL OR FAX ON
Jul/21/2010

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision lumbar laminectomy, disectomy at L2/L3, hardware removal, repair of pseudoarthrosis at L3/4, laminectomy at L4-S1 with 2 day inpatient stay--CPT Codes 63042,63044,69990-99, 22612, 22614, 22851, 20938, 22842, 22558, 20975, 63685-99, 22325 at L2/3; 22852 at L3/4 and exploration of arthrodesis L4-S1.

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
DC medical report 08/26/08, 03/08/10
Dr. operative report 10/24/08
Dr. office note 08/25/09
Bone scan report 09/19/09
Lumbar MRI report 09/19/09
Dr. Designated Doctor Evaluation 02/19/10
DC office note 03/08/10
Dr. CT scan review 05/03/10
Dr. office notes 05/04/10, 06/08/10
Dr. CT myelogram review 06/08/10
CT/myelogram report 06/07/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with a low back injury on xxxxx when he tripped and fell over a safety belt on a wheelchair lift. The claimant had a history of L4-5 and L5-S1 fusion in 2000. The claimant had an MRI on 03/13/07 that showed post op changes at L4-5 and L5-S1 with patent spinal canal and facet arthropathy of the lumbar spine. A lumbar CT scan on 04/20/07 showed a disc bulge at L3-4, leading to moderate stenosis of the spinal canal and mild left sided neural foraminal stenosis. MRI of the lumbar spine on 06/08/07 showed an annular disc bulge at L3-4 with mild bilateral foraminal narrowing. The L4-5 level revealed a solid interbody fusion and laminectomy. Facet joint arthrosis was seen with mild bilateral foraminal encroachment. At L5-S1 interbody fusion was noted along with laminectomy. There was facet joint arthrosis with mild bilateral foraminal encroachment. The claimant was treated with epidural steroid injection and L4-S1 medial branch blocks. He underwent a chronic pain management program in early 2008.

On 10/24/08 Dr. performed exploration of L4-5 and L5-S1 and a decompressive laminectomy and fusion at L3-4. The claimant continued to have low back and lower extremity pain. A 02/27/09 lumbar CT scan showed post surgical changes L3 through S1; status post fusion with hardware posteriorly at L3-4 and cage devices at L4-5 and L5-S1. There was bilateral neuroforaminal narrowing at L5-S1. MRI of the lumbar spine on 09/19/09 showed mild acquired spinal stenosis L2-3 level and post op changes from L3 to S1.

A designated doctor exam was done on 02/19/10 by Dr.. The claimant had tenderness of the paraspinal muscles and lumbar spine and sciatic notch. Supine straight leg raise was 20 degrees on the right and 30 on the left. Seated straight leg raise was 30 degrees on the right and 40 on the left. Sensation to pinprick and light touch was decreased to the right lower extremity in all dermatomes. Knee and ankle jerks were 0/0. Muscle strength in the quads and hamstrings was 4/5; ankle extensors and flexors 4/5; and great to extensors 4/5. There was atrophy on the left. The claimant had 2 out of 8 positive Waddell's which the physician noted was not significant for symptom magnification. Dr. opined that the claimant was permanently disabled.

Dr. chiropractor, referred the claimant to Dr. for a second surgical opinion. Dr. evaluated the claimant on 05/04/10. Complaints of progressive back pain and bilateral leg pain with numbness and tingling worse on the right were noted. The claimant was using a cane. Lumbar flexion/extension x-rays were done with findings per Dr. of L4-5 and L5-S1 laminotomy with bilateral BAK cages with no posterior instrumentation and no evidence of posterior fusion. L3-4 revealed complete decompression with anterior cages, posterior pedicle screws, and fixation with global bone graft. L2-3 revealed a retrolisthesis at 7 millimeters in extension, which remained 7 millimeters in flexion with facet subluxation and foraminal stenosis. Extension angle measured 16 degrees. On exam the claimant had a posterior extensor lag, mild paravertebral spasm, positive sciatic notch tenderness bilaterally, positive flip test bilaterally, positive Lasègue bilaterally at 45 degrees, positive Bragard's on the right, hypoactive knee jerks, absent posterior tibial tendon jerks, hypoactive ankle jerks bilaterally, paresthesias in the L3, L4 and L5 nerve root distribution on the right and S1 nerve root distribution on the left, mild weakness of gastroc bilaterally and quadriceps on the right and EHL (extensor hallucis longus) on the right. The impression was failed lumbar spine syndrome with adjacent segment disease. Dr. reviewed the 02/27/09 CT scan and noted findings of contained disc herniation graded at stage II with annular herniation and nuclear protrusion at L2-3 with spondylolisthesis and stenosis.

Lumbar CT/myelogram was done on 06/07/10 with the report showing solid fusions at L4-5 and L5-S1. At L3-4 the anterior graft was not incorporated into the inferior end plate of L3. The left posterolateral fusion mass was solid with very little bone graft on the right. At L4-5 there was a left sided osteophyte near the uncovertebral joint with impression on the left L4 nerve root. At L5-S1 there was a solid fusion with granulation tissue abutting the S1 nerve root sleeves and mild impression on the exiting left L5 nerve root in the neural foramen by

osteophytes. At L2-3 there was mild loss of vertebral disc height with 3 millimeters of retrolisthesis and 3 millimeters in AP dimension posterior annular disc bulge.

At the follow up visit of 06/08/10 Dr. noted unchanged symptoms and exam findings. CT/myelogram was noted to show post op changes with laminotomy and interbody cages at L4-5 and L5-S1 with significant stenosis compromising the dye flow and nerve roots to the L4 on the left and S1 bilaterally with L5-S1 on the left stenosis. The claimant had anterior screw penetration of the pedicle screws bilaterally at L4 with pseudoarthrosis at L3-4 interbody cage, and HNP with stenosis at L2-3. The impression was failed lumbar spine syndrome with adjacent segment disease, pseudoarthrosis and malplaced hardware. Dr. recommended total laminectomy at L4-5 and L5-S1; repair pseudoarthrosis at L3-4, decompression and global arthrodesis at L2-3. The surgery was denied on peer reviews of 06/15/10 and 06/22/10.

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

There is no evidence of radiograph instability in that there is a retrolisthesis that is fixed. There is no evidence of progress neurologic deficit, tumor or infection. This most certainly is a complex spine with previous surgeries noted and other confounding issues such as symptom magnification on evaluation. Further surgery is not indicated or medically necessary based on the available medical records for review.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Low Back: fusion

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)