Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/25/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Revision lumbar screws
Decompression

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

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. 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 Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Revision lumbar screws Upheld
Decompression Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Letter by dated 2/8/2010
2. Fax cover sheet by dated 2/5/2010
3. Letter by dated 2/4/2010
4. Request for a review by an independent review organization by MD dated 2/2/2010
5. Peer review by MD dated 1/13/2010
6. Letter by MD dated 1/8/2010
7. Reconsideration request by MD dated 1/5/2010
8. Letter of reference by MD dated 12/24/2009
9. Utilization review referral by MD dated 12/18/2009
10. Radiology report by MD dated 12/2/2009
11. Evaluation note by MD dated 9/15/2009-12/16/2009
12. Radiology report by MD dated 8/10/2009
13. IRO request form by MD dated unknown
14. ODG integrated treatment/disability duration guidelines for low back problems by author unknown dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Per the 9/15/2009 office note, the injured employee is a male with chronic low back pain radiating into both lower extremities. He has had 3 prior lumbar operations last done in 1998. He slipped on ice and fell to the floor as a xx on xx/xx/xx. He has had increasing back and leg pain rated 10/10. Treatments include hydrocodone and epidural steroid injection which did not help at all. MRI Lumbar X-rays on 12/2/2009 revealed stable lumbar spine appearance with no evidence of abnormal movement at the operative/fused levels with solid appearing bone graft elements seen L4-L5-S1. MRI lumbar spine on 8/10/2009 notes broad based disc bulging at L1-2 with mild spinal canal stenosis. At L3-4 broad based disc bulge, mild degenerative facet disease and ligamentum hypertrophy causing mild spinal stenosis. There was a prior laminectomy at L3-4 and L5-S1 without stenosis or disc protrusion. Mild bilateral L1, L2, L3 neural foraminal stenosis due to lateral extension of bulging disc into neural foramina as well as degenerative facet disease. There was moderate compression of superior endplate of L4 without marrow edema, likely chronic. Nearly fused L5-S1 and partially fused L4-5 disc spaces. Annular tears at L1-2 and L2-3 levels seen posteriorly. EMG/NCS of lower extremities do not reveal active lumbar radiculopathy. Left S1 transforaminal ESI did not help. He has been treated with physical therapy without relief. Examination showed decreased lumbar range of motion, no reflex at the right ankle, decreased sensation on the left thigh, straight leg raises negative, and FABER positive on the right and negative on the left. The patient has difficulty walking and reports 5/5 strength throughout.

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

There is no rationale provided for the requested surgery. There is nothing to suggest that the degenerative changes in the upper lumbar spine caused the injured employee's current subjective complaints of pain and dysfunction. Diagnostic studies do not suggest radiculopathy and no recent electrodiagnostics have been performed to confirm a possible radiculopathy. The request will lead to a completely fused spine from L1 to S1 via lumbar review revision with laminectomy and fusion L1-4 with possible bone stimulator and subsequent XLIF L1-4. The rationale for that request is absent from the documentation and is not recommended by ODG. There is no concrete evidence of pseudarthrosis since the MRI which reveals "partial fusion" and plain films which reveal "solid fusion" are conflicting. Spinal instability is not documented nor is neural arch defect. ODG does not recommend fusion in patients with more than a 2 level pathology and this is a request for a 3 level procedure. Further, psychological screening has not been done and revision surgery is strongly cautioned against given a less than 50% success rate. In addition to the fusion not being recommended by ODG, the decompression is not recommended since there is no evidence provided in the medical records to suggest radiculopathy, i.e. negative straight leg raises, normal leg strength and lack of nerve root compression on MRI at the levels requested for surgery. Based on the information provided, the recommendation is to uphold the prior denials for revision lumbar laminectomy and fusion L1-4 with XLIF L1-4.

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)