

SENT VIA EMAIL OR FAX ON
Dec/02/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Laminotomy (Hemilaminectomy), with decompression of nerve Root (s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assis

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

Orthopedic spine surgeon, practicing neurosurgeon

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

Preauthorization review 10/19/11
Preauthorization review 10/21/11
Preauthorization or concurrent review request form
Office notes Dr. 11/23/09-10/10/11
MRI lumbar spine 05/16/11
Psychological evaluation 06/03/11 and 06/05/11
X-rays lumbar spine 04/21/11, 09/23/10, 07/14/09
Operative report removal of subcutaneous spinal fusion stimulator battery 04/13/11
Designated doctor evaluation 02/17/11
Physical therapy evaluation and discharge summary 04/05/10 and 04/19/10
Discharge summary following decompression L5-S1 laminectomy and interbody fusion 01/05/10

Psychological evaluation and treatment summary 09/11/09-11/04/09

Independent medical exam 11/18/10

Physical therapy evaluation and notes 03/05/09 and 03/09/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who slipped and fell at work on xx/xx/xx. After failing to improve with conservative treatment, the claimant underwent surgical intervention on 01/05/10 with decompressive L5-S1 laminectomy, anterior interbody fusion, and posterolateral fusion, with bilateral L5-S1 pedicle screw plates. Office note dated 01/20/11 noted the claimant is a little over a year after posterior L5 decompression fusion and instrumentation. X-rays were noted to show solid fusion with normal alignment. The claimant has some residual lumbar pain with a little residual right leg pain, although not truly radicular. He uses a cane. He is able to stand on toes and heels. The claimant would probably benefit by lumbar epidural steroid injection, but this has not been approved. It is noted that further physical therapy was not allowed. The claimant continues to take Hydrocodone 10 mg and Soma was switched to Zanaflex 4 mg tid. The claimant also takes Motrin 800 mg tid. The claimant wanted his right paralumbar subcutaneous spinal fusion stimulator battery removed since it was irritating him, and the battery was removed on 04/13/11. Office note dated 10/10/11 indicated the claimant has severe mechanical lumbar pain and radicular pain in both legs with numbness, dysesthesias and weakness. It was noted that CT myelogram of the lumbar spine was denied. It was noted the claimant has had extensive physical therapy and chiropractic care and has had psychological counseling. He was recommended to undergo posterior L4-5 decompression, fusion and instrumentation.

A utilization review determination dated 10/19/11 recommended non-certification of request for posterior L4-5 decompression, fusion, and instrumentation. The reviewer noted that imaging studies demonstrate the claimant has broad based bulge at L4-5, mild in nature, causing mild encroachment upon the anterior aspect of the dural sac and neural foramina. At L5-S1 there are postoperative changes secondary to previous fusion. There is mild contrast enhancement at the margin of the stimulator, possibly indicative of postoperative seroma versus focal abscess. Records indicate the claimant has diminished range of motion and weakness of quadriceps, foot dorsiflexors and plantar flexors. Straight leg raise is positive. He has dysesthesias and weakness noted. He has been sent for psychological counseling prior to lumbar fusion and has had psychological counseling and testing on 06/03/11. The result of that testing indicated the claimant has significant anxiety and depression. Medical records do not demonstrate other psychological interventions after this exam. Current evidence based guidelines indicate there should be psychosocial evaluation prior to fusion procedures. Of note this is reexploration and fusion after initial fusion. Usually psychological evaluation is not required for preoperative indication for reoperation. However, it is noted this claimant has significant anxiety and depressive symptoms, and these issues should be addressed prior to proceeding with surgery. The records do not demonstrate any other psychological evaluation after 06/05/11, and therefore the request is not considered medically necessary.

An appeal request for posterior L4-5 decompression, fusion and instrumentation was reviewed on 10/21/11, and the requested surgery was determined as not medically necessary. The clinical records indicate the claimant has history of low back injury on xx/xx/xx, and is reported to have failed conservative treatment and ultimately taken to surgery and underwent 360 degree fusion at L5-S1 with placement of interbody cages and posterior instrumentation. Postoperatively the claimant was noted to have improvement for approximately 1 month and subsequently digressed while receiving chiropractic and physical therapy. Records further indicate the claimant has comorbid psychiatric issues for which he is receiving ongoing behavioral therapy. There is no indication at the present time that the claimant has completed this treatment and has been cleared for surgical intervention. Records note that postoperatively the claimant has neurological deficits. However, it is unclear if these represent acute or chronic findings. Records indicate that Dr. has asked for a CT myelogram of the lumbar spine which in fact would be indicated given the equivocal findings at L4-5. Further it has not been established that the L4-5 level is a pain generator. Of note, the findings at L4-5 appear to be unchanged from the claimant's postoperative status

and therefore these findings at L4-5 would not be considered adjacent segment disease. Based upon the clinical records as provided, the claimant is not a candidate for extension of fusion to the L4-5 level. Further clinical information in addition to an updated psychological clearance would be required to establish the medical necessity of the request.

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

Based on the clinical information provided, the proposed posterior L4-5 decompression, fusion and instrumentation is not indicated as medically necessary. The claimant is noted to have sustained an injury secondary to slip and fall on xx/xx/xx which resulted in the claimant undergoing a 360 instrumented fusion at L5-S1 performed on 01/05/10. Records indicate the claimant received temporary improvement following surgery, but continued to complain of low back pain with pain radiating to lower extremities. MRI of lumbar spine performed on 05/16/11 revealed postoperative changes at L5-S1 level secondary to PLIF procedure. At L4-5 there is mild broad based disc bulging causing mild encroachment upon the anterior aspect of dural sac and neural foramina. This is slightly more pronounced laterally to the right. Degenerative changes were present involving facet joints with facet hypertrophy noted. There is thickening of the ligamentum flavum posteriorly. As noted on previous reviews, the claimant was noted to have significant anxiety and depression. The claimant was recommended to participate in individual psychotherapy, but no subsequent treatment notes or reevaluation was documented following evaluation on 06/03/11 and 06/05/11. It was also noted that the findings at L4-5 appear to be unchanged from preoperative status and would not be considered adjacent segment disease. Given the current clinical data, medical necessity is not established for the proposed L4-5 decompression and fusion with instrumentation. Accordingly, the previous denials should be upheld on IRO.

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 KNOWLEDGBASE
- 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)