

SENT VIA EMAIL OR FAX ON
Feb/17/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L5/S1 anterior and posterior spinal fusion with instrumentation and decompression with 3-5 day LOS

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)

L5-S1 anterior and posterior spinal fusion with instrumentation and decompression is medically necessary

3-5 day length of stay--4-5 days are not medically necessary. Guidelines recommend 3 days (see below)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx-year-old male who injured his back while trying to lift objects weighing approximately two hundred eighty (280) pounds with the assistance of another person. On 12/12/05 the claimant underwent L3-L5 laminectomy and decompression; posterior spinal fusion with Laguna pedicle screw instrumentation and interbody fusion. The claimant reported that he obtained relief of his back pain for approximately two (2) weeks after his surgery. Throughout 2006, the claimant followed up with Dr. post operatively. The claimant had some post-operative wound healing problems which required an inpatient admission in early January, 2006 at which time an incision, debridement and exploration of his surgical wound was performed. The infectious disease service was consulted as well. The visit of

March 2006 noted that the wound had healed and the fusion appeared to be progressing per x-ray. Dr. ordered formal physical therapy at that time. The claimant was again seen on 08/09/06 and it was noted that the claimant stated his pain level was improved but still he had some residual pain. During 2007 Dr. was following the claimant every six (6) months. The claimant completed a Functional Capacity Evaluation, which showed that he could safely function at light to medium physical demand.

On 01/10/08 the claimant was seen by Dr. for routine follow-up at which time it was noted that the claimant was doing about the same and his back generally did not bother him but it did flare-up with physical activity. Dr. did x-rays, which showed that the hardware was intact and the fusion was stable. On the claimant's six-month follow up visit dated 09/04/08 Dr. noted that the claimant had increased pain, which was mainly in the back over the right side of the incision. The X-rays showed the fusion to be stable and the hardware intact without any evidence of lucency or change in position. He recommended a Medrol Dosepak, muscle relaxant and anti-inflammatories.

There was gap in the records submitted from 09/04/08 until 01/13/10 when the claimant underwent an MRI of the lumbar spine with and without contrast for the diagnosis of recurrent back pain since surgery 2005. The MRI showed the following: Bilateral interpedicular screws at L3, L4 and L5 with surrounding metallic artifact. There was evidence of previous bilateral laminectomies at L4-5; a mild generalized disc bulge and moderate bilateral facet hypertrophy at L5-S1, which resulted in moderate narrowing of the neuro foramina bilaterally at this level.

A Functional Restoration Program discharge summary dated 01/20/10 stated that the claimant completed twenty out of twenty (20 out of 20) authorized program days. The claimant had met his program goals, was weaned off of opiates, dramatically reduced amount of his alcohol intake daily and was discharged on Suboxone, Librium, Arthrotec, Voltaren gel, Ambien CR. The summary stated that the claimant reported a fairly high concern over re-injuring himself and had been cautioned on his limitations.

From 01/22/10 to 04/10/10 the claimant regularly followed with Dr. for continued complaints of severe, worsened back and left leg pain with numbness and tingling. The claimant stated that the intensity of the pain was equal between his back and leg. The claimant was treated conservatively with oral steroids, anti-inflammatories, a back brace and physical therapy all of without any relief of his symptoms. The claimant also required increased amounts of pain medication. Dr. noted the results of the MRI: disc space narrowing and retrolisthesis at L5-S1, the disc below his previous fusion, with significant foraminal and lateral recess stenosis with disc space narrowing at the levels above. Dr. examination findings were as follows: decreased range of motion with pain on motion of his back especially with extension. Straight leg raise was positive on the left with decreased sensation at the L5-S1 distribution on the left with weakness of plantar flexion on the left compared to the right. There was a diminished left S1 reflex on the right as compared to the left. His diagnosis was L5-S1 listhesis and stenosis below the previous L3-L5 fusion and noted that the claimant was quite symptomatic, unable to walk or sleep. Dr. noted that the MRI and X-rays showed instability and stenosis below the previous fusion and recommended additional surgery to address the claimant's pathology with the proposed procedure of an anterior and posterior fusion with decompression and instrumentation of L5-S1.

In preparation for surgery Dr. ordered a discogram, which was denied. The claimant underwent the following diagnostic studies: on 05/04/10 a Myelogram of the lumbosacral spine showed that the nerve root sleeves were not optimally seen due to the hardware. There were no gross nerve root sleeve amputations. The Post Myelogram CT Scan showed post op changes at L3-4; the disc spaces were solidly fused. Left posterior fusion mass was continuous and the left L3 facet was partially fused. There was mild left lateral recess stenosis and moderate to marked left foraminal narrowing with mild effacement of the left L3 nerve root sleeve. The L4 nerve root sleeves filled normally. Bilateral transpedicular screws with posterior instrumentation were present at L3-4 without evidence of loosening or migration. At L4-5 there were post-op changes. Attempted anterior fusion was not convincingly continuous. The left facet joint was fused; left posterior fusion mass was continuous from L4-5. Moderate right foraminal narrowing was present. There was no

displacement of the L4 nerve root sleeves. The L5 nerve root sleeves were moderately underfilled bilaterally. At L5-S1 moderate disc space narrowing was present. There was 2 mm retrolisthesis of L5 upon S1. A 4 or 5 mm bony and discal broad based posterior protrusion very mildly indented the sac. Marked bilateral facet arthrosis was present. There was a superimposed right posterolateral bony and discal protrusion. There was no central canal stenosis. Bilateral recess stenosis was present, severe on the right. There was very marked bilateral foraminal narrowing. There was effacement of the left, effacement and displacement of the right L5 nerve root sleeve/ dorsal root ganglion. The S1 nerve root sleeves were not visibly effaced and filled normally.

The claimant was seen on 05/06/10 and 07/20 /10 by Dr. for continued severe pain unrelieved by any medications. The claimant's examination remained the same with the addition of bilateral leg weakness, which caused the claimant to fall. Dr. noted that the claimant's back was bruised and the examination findings were unchanged from the last visits. Dr. continued with oral pain medications and ordered lateral lumbar sacral x-rays with flexion and extension views.

On 08/18/10 the claimant underwent x-rays of the lumbosacral spine with flexion/extension views which showed the following: Metallic fixation from L3-L5 with interbody fusion grafts evident within the L3-4 and L4-5 disc spaces with areas of slight subluxation in lumbar spine as described with approximately 3 mm of instability at L5-S1 level evident on the images provided. There was evidence of approximately 4 mm of retrolisthesis of L5 on S1 seen on the extension view, which reduces to about 1 mm on the flexion view. On 08/19/10 the claimant was again seen by Dr. at which time he reviewed the x-rays and noted the flexion and extension views showed instability below the previous fusion and again recommended surgery.

On 09/14/10 the claimant underwent a Psychological Evaluation. Dr.'s opinion was as follows: the claimant did not present any psychological issues that would stop him from being a candidate for back surgery. However his response to treatment and ability to return to a more normal life might be enhanced by addressing his symptoms of depression through a brief course of anti-depressant medication. The claimant had several positive prognostic indicators that suggested a positive response to a surgical procedure. He was psychologically stable. The claimant was again seen in follow up on 10/21/10 by Dr. who noted that the claimant did not have any changes in the severity of his symptoms or his physical examination and noted that they were in the appeal process for authorization of the proposed surgical procedure. The records submitted included Peer Reviews dated 01/24/11 and 01/31/10 which both denied the proposed surgery.

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

The question in dispute is whether or not an L5-S1 anterior and posterior spinal fusion with instrumentation and decompression with 3-5 day length of stay is medically necessary. Obviously 2 previous reviewers have felt that some type of operative procedure is necessary, however they did not feel that both an anterior and posterior fusion was indicated and that either an anterior or a posterior fusion was only needed. Clearly these medical records document L5-S1 instability, with spinal stenosis and foraminal stenosis in a patient who has back and radicular leg complaints and a previous L3-L5 fusion. It would appear based on the ODG Guidelines for instability, that a lumbar fusion is acceptable, however obviously there is discussion as to what type of fusion should be performed. This reviewer believes that different practioners feel more comfortable with different types of fusions and once the determination is made that a decompression and fusion is indicated then the practioner should be allowed to choose what type of operative procedure would be best for that claimant. Therefore this reviewer does not have as much issue with the fact that a lumbar instrumentation/decompression and fusion at L5-S1 is indicated. The unresolved issue in this reviewer's mind is that a 3-5 day length of stay has been requested whereas the Milliman Guidelines indicate a 3-day length of stay and Official Disability Guidelines describe a 3-day median length of stay. Therefore while the lumbar decompression and fusion may in fact be medically necessary, the non-specific length of stay would not be medically necessary. The lumbar fusion with a 3 day length of stay would be medically necessary based on review of this medical record and documented progressive loss of function and instability at a junctional

level next to a previous 2 level fusion.

REFERENCES: Official Disability Guidelines, Treatment in Worker's Comp 16th edition, 2011 Updates. Low Back Chapter

ODG hospital length of stay (LOS) guidelines:

Lumbar Fusion, anterior (icd 81.06 - Lumbar and lumbosacral fusion, anterior technique)

Actual data -- median 3 days; mean 4.2 days (± 0.2); discharges 33,521

Best practice target (no complications) -- 3 days

Lumbar Fusion, posterior (icd 81.08 - Lumbar and lumbosacral fusion, posterior technique)

Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761

Milliman Care Guidelines® Inpatient and Surgical Care 14th Edition

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)