

SENT VIA EMAIL OR FAX ON
Jun/08/2011

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5/S1 retroperitoneal anterior interbody fusion posterior facet fixation with iliac crest aspiration

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

Board Certified Orthopedic 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

1. submission and response to IRO 05/20/11
2. Utilization review determination 04/27/11 regarding non-certification arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression) lumbar
3. Utilization review determination 05/13/11 regarding non-certification appeal request arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression) lumbar
4. Workers' compensation utilization review request
5. Psychiatric progress notes Dr. 10/29/10, 02/15/11 and 03/16/11
6. Office visit notes Dr. 10/28/10 through 03/14/11
7. Electrodiagnostic results 12/17/08
8. Office visit notes Dr. 01/07/10 through 12/02/10
9. MRI lumbar spine 11/25/08, 01/12/09 and 06/01/10
10. X-rays thoracic spine 09/22/08

11. MRI cervical spine 11/25/08

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was injured when a cable broke amputating his left arm below the elbow. He also was struck in the back by a large metal bell. The injured employee presented with complaints of back pain/lumbar radiculopathy. Electrodiagnostic testing performed 12/17/08 reported EMG evidence of chronic right S1 radiculopathy and chronic left L5 radiculopathy. MRI dated 11/25/08 revealed evidence of disc degeneration at L5-S1 with a small posterocentral right paracentral radial annular tear without associated disc protrusion or extrusion. The width of the spinal canal was normal with no other significant findings noted. Repeat MRI of the lumbar spine on 01/12/09 revealed L5-S1 central annular tear and facet arthrosis causes no significant canal stenosis or neural foraminal narrowing. MRI on 06/01/10 reported L5-S1 annular tear seen in the midline posteriorly; L5-S1 disc desiccation. There was no canal or significant foraminal narrowing seen. Ligaments and facets were unremarkable. The injured employee was treated with therapy, medications. The injured employee also had epidural steroid injections and facet blocks without significant improvement. The injured employee was seen in follow up by Dr. on 03/14/11 with back pain/lumbar radiculopathy located in the thoracic spine and lumbosacral spine. Symptoms were noted to start two years ago. Pain radiates down both legs and bilateral hips. The injured employee also complained of neck pain and states every time he moves his neck around it pops and causes major headaches and dizziness. On examination motor strength was normal throughout. Sensation was diminished in the left C5, C6, C7 and right C7 distribution.

A utilization review determination dated 04/27/11 determined non-certification of request for L5-S1 anterior interbody fusion. The reviewer noted that the injured employee was complaining of low back pain with radiation to the bilateral lower extremities on most recent note of 03/14/11. There were no positive physical findings documented in this note. Based on the lack of documentation of any positive physical examination findings and no documentation of any instability the proposed surgery was not recommended as medically necessary.

A utilization review dated 05/13/11 determined that an appeal request for anterior interbody fusion L5-S1 was non-certified as medically necessary. Reviewer noted that this injured employee has degenerative disc disease but no evidence of any disc herniation and no evidence of any nerve compression. There were no radiographic findings to explain the injured employee's complaints of leg pain. The reviewer noted Official Disability Guidelines provide that fusion may be indicated in patients who have subluxation, spondylolisthesis, fracture, dislocation or frank neurogenic compromise which the injured employee does not have and therefore is not a surgical candidate.

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

Based on the clinical data provided, the request for L5-S1 retroperitoneal anterior interbody fusion posterior facet fixation with iliac crest aspiration is not indicated as medically necessary. The injured employee is noted to have sustained traumatic injury on xx/xx/xx resulting in amputation below the left elbow. The injured employee also sustained an injury to the back when he was struck by a large metal bell. The injured employee complained of low back pain radiating to the bilateral lower extremities; however, there were no objective findings on clinical examination of motor, sensory or reflex deficits in the lower extremities. MRI revealed degenerative changes at L5-S1 with no evidence of neurocompressive pathology and no evidence of motion segment instability at any level of the lumbar spine. The injured employee was cleared for back surgery from a psychiatric perspective per report 03/16/11; however, the injured employee otherwise does not meet criteria for lumbar spine fusion.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL

BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES