

SENT VIA EMAIL OR FAX ON
May/17/2011

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior/Posterior Fusion L4/5; Hardware Removal L5/S1 Exploration Fusion;
Reinstrumentation/Extension L4-L5; 2 day inpatient stay

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. Utilization review determination 03/29/11 regarding non-certification anterior / posterior fusion L4-5; hardware removal L5-S1 exploration of fusion; reinstrumentation / extension L4-5; two day inpatient stay
2. Utilization review determination regarding non-certification reconsideration request anterior / posterior fusion L4-5; hardware removal L5-S1 exploration of fusion; reinstrumentation / extension L4-5; two day inpatient stay
3. Fax cover sheet 03/23/11 requesting preauthorization for spinal surgery
4. Office notes Dr. 10/08/03-03/08/11
5. Operative report lumbar interbody fusion 08/08/03
6. Operative report removal of antibiotic impregnated beads, irrigation and debridement surgical wound, placement of tobramycin impregnated methacrylate beads
7. Evaluation report Dr. 01/27/11
8. Operative note left L4 and left L5 transforaminal epidurograms and epidural steroid injections 01/06/11
9. CT myelogram lumbar spine 10/19/10
10. Lumbar spine radiographs 10/19/10
11. MRI lumbar spine 12/11/09
12. Fax cover sheet and appeal letter Dr. 04/08/11 regarding denial of surgery

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was descending a ladder when he felt pain in his low back. The injured employee is status post lumbar surgery on 08/08/03 with interbody fusion L5-S1. MRI of lumbar spine dated 12/11/09 reported a limited study due to motion and susceptibility artifact. There was

no appreciable foraminal narrowing or canal stenosis with respect to upper lumbar spine above L4. There were postsurgical changes noted. The injured employee underwent CT myelogram of lumbar spine on 10/18/10. On myelogram there was mild posterior narrowing and retrolisthesis of L4-5 with prominent anterior extradural defect at this level. There was less complete filling of nondisplaced left L5 nerve root compared to right side. At L5-S1 there is anterior and posterior fusion with preservation of interspacing and unremarkable appearance of S1 roots. Post myelogram CT revealed L2-3 and L4-5 interspace narrowing; L4-5 diffuse annular bulge and central to left sided focal herniation with mass effect on left L5 root; L5-S1 anterior and posterior fusion. Lumbar myelogram scout films on 10/19/10 revealed L5-S1 anterior and posterior fusion, minimal to mild narrowing L2-3 and L4-5, and minimal retrolisthesis L4-5.

Utilization review determination on 03/29/11 found a request for anterior / posterior fusion L4-5, hardware removal L5-S1 exploration of fusion, reinstrumentation / extension L4-5 with 2 day inpatient stay to be non-certified as medically necessary. The reviewer noted the injured employee complains of severe back pain that radiates down his leg primarily in L4 distribution into the calf. He also has symptoms extending into his left foot intermittently in an L5 distribution. The reviewer noted that the injured employee's symptomatology was nonspecific for radiculopathy. There was also no clear documentation of conservative treatment with no physical therapy progress notes and no documentation of optimized pharmacotherapeutic utilization in conjunction with VAS scoring and rehabilitative support. No official lumbar x-rays with flexion / extension views were noted to document spinal instability. The reviewer also noted hardware removal was not addressed by reference guidelines.

A reconsideration / appeal utilization review was performed on 04/20/11 and determined the appeal request for anterior / posterior fusion L4-5, hardware removal L5-S1 exploration of fusion, reinstrumentation / extension L4-5 with 2 day inpatient stay to be non-certified as medically necessary. The reviewer noted that the injured employee was noted with back pain that has become progressively worse. Lumbar spine CT myelogram showed disc herniation at L4-5 with disc collapse causing impingement on L5 nerve root with decreased filling. However, it was noted there was no clear documentation of recent comprehensive clinical evaluation that was specific to correlate with the diagnosis of lumbar radiculopathy. Furthermore, it was noted that documentation of failure of conservative treatment including physical therapy progress notes and adequate pain medications were not provided for review. It was noted there was no documentation regarding the response to epidural steroid injection including sustained pain relief, increased performance in activities of daily living, and reduction of medication use. Lastly, the record did not include preoperative psychiatric evaluation which is indicated to assess the injured employee's realistic expectation for procedure.

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 anterior / posterior fusion L4-5, hardware removal L5-S1 exploration of fusion, reinstrumentation / extension L4-5 with 2 day inpatient stay is indicated as medically necessary. The injured employee sustained an injury to low back in xxxx and underwent posterior lumbar interbody fusion at L5-S1 performed 08/08/03. The injured employee continued to complain of low back pain radiating to lower extremities primarily in L4 distribution. CT myelogram performed 10/19/10 revealed postoperative changes with anterior interbody and bi-pedicular fusion at L5-S1. At L4-5 there was posterior narrowing and retrolisthesis with prominent anterior extradural defect. There was less complete filling of nondisplaced left L5 nerve root compared to right side. A transforaminal epidural steroid injection was performed on 01/06/11. Records indicate the injured employee was taking medications including Skelaxin, Norco, Medrol DosePak and Ibuprofen. Records further indicate physical therapy, NSAIDs, and muscle relaxants have failed to control symptoms. The injured employee has evidence of solid arthrodesis at L5-S1. He has developed findings at the adjacent segment immediately above the previous fusion. Notes indicate that transforaminal epidural steroid injection brought the injured employee's pain level from 5 to 0/10. Since then the injured employee's back pain has become progressively worse. It is noted the L4 segment is slightly kyphotic. The injured employee's

pathology at L4-5 level is a known complication of lumbar fusion with development of adjacent segment disease. Based on the clinical information provided, it appears the claimant does have objective findings of significant pathology at L4-5 level, with solid fusion at L5-S1. The injured employee has failed to improve with conservative treatment including medications, physical therapy. He did have temporary relief with diagnostic transforaminal epidural steroid injection. As such, the proposed surgical procedure is recommended as medically necessary. As this is revision surgery, psychological evaluation is not needed.

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)