

SENT VIA EMAIL OR FAX ON
Nov/09/2011

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3/4 Posterior Spinal Fusion and L4/5 Re-Exploration with 4 day Inpatient Stay

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

Orthopedic Surgery

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 determination 09/01/11

Preauthorization determination 10/07/11

Notice of disputed issues and refusal to pay benefits 08/26/11

Peer review Dr. 05/29/11

Preauthorization request form and second request

Office notes Dr. 02/16/10-09/12/11

X-ray lumbosacral spine 02/16/10

Recommended medical exam reports Dr. 10/28/04, 06/28/05, 09/26/06, 01/10/08, 05/14/09, 09/02/10

Comprehensive diagnostic interview Dr. 06/29/10

Offices notes Dr. 07/06/04-01/21/10

CT myelogram lumbar spine 01/14/10

Office notes Dr. 12/18/03-08/27/09

Procedure note spinal cord stimulator trial 05/15/09 and placement of permanent spinal cord stimulator 08/07/09

Office notes Dr. 04/16/1999-02/02/09

Physical therapy notes 12/16/08-01/19/09

X-rays lumbar spine 10/04/07, 07/17/07, 06/05/07, 04/25/07

Medical records / peer review Dr. 05/08/07

Operative report 04/25/07

Consultation report 04/25/07

Discharge summary 04/27/07
Medical records / peer review Dr. 09/28/05
CT myelogram lumbar spine 09/19/05
MRI lumbar spine 04/15/03
Medical records / peer review Dr. 03/21/00
Operative report 06/07/99
Spinal surgery second opinion report Dr. 05/05/99
Lumbar myelogram with post CT 03/30/99

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he was injured after falling backwards down a ladder jack. Per operative report dated 06/07/99 the claimant was status post previous L4-S1 fusion, and underwent right L3-4 hemilaminotomy foraminotomy and discectomy on this date. The patient subsequently underwent lumbar fusion L3-4 through L5-S1 on 04/25/07. After undergoing spinal cord stimulator trial, the claimant underwent permanent placement of spinal cord stimulator on 08/07/09. The patient was seen on 09/21/11 for recheck of back pain. He complains of low back pain and bilateral leg pain. It was noted that on last visit of 02/24/11 surgery was to be appeal and surgery was denied again. The claimant states pain is constantly getting worse. He has numbness in his feet and tingling that goes down back of left leg. Right is worse than left with a lot of hip pain as well. He is taking Hydrocodone (about 5 a day), Soma (prn), Zipsor, and Lyrica for pain.

A preauthorization review dated 09/01/11 recommended non-certification of L3-4 posterior spinal fusion at L4-5 reexploration with 4 day inpatient stay. It was noted the available medical records indicate the claimant has failed back surgery syndrome and has undergone multiple operative interventions without improvement. There is no indication from the current record that the claimant has evidence of pseudoarthrosis at L4-5. The claimant has previously been evaluated by other surgeons who did not recommend performance of surgery at the L3-4 level. The record provides no recent data which establishes the claimant has exhausted conservative treatment. It was further noted that given the claimant's history of multiple surgeries, it would be prudent to perform preoperative psychological evaluation. The record also does not contain any recent physical examination by Dr. It was further noted that the preponderance of the data was suggestive the claimant is unlikely to receive any benefit from additional surgical interventions.

Appeal request for L3-4 posterior spinal fusion at L4-5 reexploration with 4 day inpatient stay was reviewed on 10/07/11 and non-certified as medically necessary. It was noted the submitted records indicate the claimant has history of multiple surgical interventions including fusion procedures for which he has made no substantial improvement. He was identified as having failed back surgery syndrome and underwent placement of dorsal column stimulator. It was noted the claimant received extensive conservative treatment in order to alleviate his low back pain. The most recent imaging study is over a year old and not appropriate for surgical planning. Additionally, given the chronicity of the claimant's condition an updated psychiatric evaluation would be indicated. It is further noted there was no instability on imaging studies. There is a lack of correlation between imaging and subjective reports. It was further noted that neurosurgeon who participated in earlier care did not recommend any additional surgeries in 2009. It was noted that any further surgical intervention has very poor prognosis noting failed back surgery syndrome and noting lack of response to dorsal column stimulator.

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

The request for L3-4 posterior spinal fusion and L4-5 reexploration with 4 day inpatient stay is not indicated as medically necessary. The claimant is noted to have sustained an injury in 1998 resulting in multiple lumbar surgeries including fusion. The claimant continues with subjective complaints of low back pain radiating to bilateral lower extremities. The claimant also is status post dorsal column stimulator implantation without significant benefit. As noted on previous reviews, the imaging studies provided are over a year old and not appropriate for surgical planning. However, it is noted there is no evidence of imaging of pseudoarthrosis at

L4-5. Given the current clinical data, medical necessity is not established, and 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 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)