

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

inpatient lumbar laminectomy with fusion/instrumentation L1-4, one-day length of stay, bone fusion stimulator, TLSO back brace

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

M.D., Board Certified 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

Official Disability Guidelines

Clinic notes Dr. dated 03/17/10, 05/03/10, 07/12/10, 09/30/10, 12/27/10, 03/31/11, 04/18/11, 05/11/11, 06/06/11, 06/29/11, 08/04/11, 08/15/11

Radiographic report 3 views lumbar spine dated 08/16/10

Radiographic report AP and lateral lumbar spine dated 12/27/10

Clinical records Dr. dated 01/20/11

Report of medical evaluation dated 01/20/11

Injured employee notice of ability to dispute MMI and IR dated 01/26/11

MRI lumbar spine dated 04/12/11

Lumbar myelogram dated 06/22/11

CT lumbar myelogram dated 06/22/11

Operative report dated 06/22/11

Operative report dated 07/20/11

Notification of adverse determination dated 08/15/11

Notification of reconsideration determination dated 09/09/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male who sustained work related injuries on xx/xx/xxxx. He is reported to have twisted and lifted and subsequently developed low back pain. On 03/30/10 he was taken to surgery by Dr. at which time he underwent a posterior L4-5 decompression and fusion with instrumentation for treatment of severe posttraumatic L4-5 disc pathology with large herniated disc. It is reported the claimant no longer has any radicular leg pain. On 05/03/10 the claimant's sutures were removed. He was continued on oral medications and referred to physical therapy. On 08/16/10 the claimant underwent repeat radiographs of the lumbar spine, which noted PLIF procedure performed at L4-5 level. Bilateral pedicle screws are present at L4 and L5 transfixing the posterior compression plates extending from L4-5. There are Interdisc spacers present within the L4-5 discs. Bilateral bony fusion processes extend from L4-5. There are bone growth stimulator electrodes overlying the operative site.

There is minimal disc disease noted at L2-3 and L3-4. Repeat radiographs were performed on 12/27/10. This study notes bony fusion masses are present and appear relatively mature. Post surgical changes at L4-5 are noted. On 01/20/11 the claimant underwent RME examination by Dr. RME notes that patient has completed 36 sessions of postoperative therapy. He reported continuous aching in low back worse with bending, standing and walking. He reports intermittent numbness to posterior right thigh and calf as well as numbness to heel on right foot. He complains of weakness to right leg and foot. His current medications include Neurontin, Hydrocodone, and Motrin.

He was previously seen by a designated doctor on 12/07/10 at which time, he was placed at maximum medical improvement and received 10% impairment. He is a one pack per day smoker. On physical examination he is 70 inches tall and weighs 206 lbs. He is well developed and well nourished. He ambulates with antalgic gait. He is able to heel walk but unwilling to toe walk claiming weakness in right foot. He uses a cane to ambulate. Lumbar range of motion is reduced. Motor strength is 5/5 with apparent voluntary give way weakness of right ankle and great toe. There is no evidence of atrophy in lower extremities by measurement. Sensation is intact. Deep tendon reflexes are 2 in knee and 1 in ankles. Straight leg raise is negative bilaterally. The claimant was opined to have 12% whole person impairment with date of MMI of 01/20/11.

He had an MRI of lumbar spine on 04/12/11. He is noted to have moderate narrowing of disc space at L1-2 with diffuse posterior hypertrophic spurring and broad based bulging of the disc noted causing mild encroachment upon the anterior aspect of the dural sac and neural foramina. There are mild degenerative changes involving the facet joints, mild thickening of the ligamentum flavum posteriorly causing mild spinal canal stenosis. At L2-3 disc space there is moderate narrowing of the disc space. There is broad based hypertrophic spurring and bulging of disc, which causes mild encroachment upon anterior aspect of the dural sac and neural foramina. Facet joint laxity is noted. There is thickening of the ligamentum flavum posteriorly. At L3-4 there is a 3 mm posterior subluxation of L3 on L4, moderate narrowing of L3-4 disc space, broad based bulging of disc is causing mild to moderate encroachment upon anterior thecal sac. There are degenerative changes present involving the facet joints. There is thickening of ligamentum flavum posteriorly. These findings cause moderate spinal canal stenosis and moderate bilateral neural foraminal stenosis. At L4-5 there are postoperative changes secondary to PLIF. Pedicle screws are present at L4 and L5 transfixing the posterior compression extending from L4-L5. At L5-S1 there is a broad based bulging of disc noted causing mild to moderate encroachment upon the anterior aspect of dural sac and neural foramina. Degenerative changes are present involving facet joints. The claimant underwent a lumbar myelogram on 06/22/11. This study notes multilevel degenerative disc disease and lumbar spondylosis.

In follow up, Dr. reported the claimant had significant weakness of quadriceps foot and great toe. It is noted that great toe dorsiflexion and plantar flexion with absent deep tendon reflexes in lower extremity. There is no definite atrophy with loss of sensation from upper thighs distally. Dr. opines the claimant developed a cauda equina syndrome. He subsequently recommended L1-4 decompression and reported that at L1-2 there was almost complete Myelographic block, which is not detailed in radiology report.

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

This patient initially sustained an injury to his low back as a result of lifting and twisting. He underwent a single level fusion at L4-5 on 03/30/10. Postoperatively the patient has had continued pain without significant improvement and has undergone additional diagnostic studies, which show evidence of stenosis above level of fusion. However, per the radiologist report this is largely mild. In addition to this, the patient has no evidence of instability on flexion / extension views that would necessitate extension of fusion from L1-4. The patient has undergone RME examination where it was noted the patient had give way weakness with no evidence of atrophy in lower extremities and was intact neurologically. The patient has not undergone preoperative psychiatric evaluation, which clearly is germane to the decision noting the claimant's lack of response to surgical intervention, and give way weakness

documented on examination. At present, the patient would not meet criteria for this procedure per ODG. The reviewer finds there is no medical necessity at this time for inpatient lumbar laminectomy with fusion/instrumentation L1-4, one-day length of stay, bone fusion stimulator, TLSO back brace.

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)