Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 09/13/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy with fusion at L2-L3 with one day length of stay

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Inpatient lumbar laminectomy with fusion at L2-L3 with one day length of stay - Upheld

The Official Disability Guidelines (ODG) for the Low Back - Lumbar & Thoracic were provided by the carrier/URA

PATIENT CLINICAL HISTORY

Dr. performed an L4-L5 and L5-S1 laminectomy and fusion using interbody technique and posterolateral technique on 01/17/04. The patient continued to

have pain and he underwent an extension of the fusion to L3-L4 on 07/05/06. At that time, he had fusion extended up to L3-L4 with bilateral L3-L4 lateral recess and foraminotomy and decompression. The patient continued not to do well, requiring multiple diagnostic studies. The battery stimulator was removed due to pain in May of 2008. Due to continued pain in January 2009, the patient had implantation of a spinal cord stimulator lead that was complicated by dura leak, which required closure of the durotomy. His back pain increased, acknowledged by Dr. to be coincident with stress in his family. The patient does not appear to have radicular pain. He had repeat CT myelogram in September of 2010 that was stable and did not show any change in his condition. Even Dr. stated on 02/21/11 that "I could find no real differences on his spinal or neurological examination and no further spinal diagnostic studies are necessary". However, due to the patient's continued symptoms, less than four months later a CT myelogram was performed with essentially the same results. Based on these imaging studies with "weakness of bilateral quadriceps", Dr. recommended a decompression and fusion.

The initial reviewer for the URA was Dr.. Dr. stated the patient did not meet the criteria and the symptoms reported included the weakness of the quadriceps and "positive straight leg raise test". However, there had been no attempt at conservative treatment and on that basis Dr. did not believe the patient met the criteria for surgical intervention.

Upon appeal to the URA, a second review was performed by Dr., a neurosurgeon. Dr. concurred with the noncertification, noting the pertinent physical findings of decreased range of motion, weakness of the quadriceps, and a positive straight leg raising sign. The increased disc space narrowing and broad based disc bulge at L2-L3 were noted, but Dr. opined that the findings on that CT myelogram were not consistent with the patient's physical examination or his symptoms and therefore denied the certification.

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

There is insufficient objective evidence in the medical records provided that the patient requires extension of the decompression and/or fusion. This patient has a spinal cord stimulator in place. This patient has failed to improve with two prior surgeries. The patient has no objective evidence requiring a fusion; that is, there is no evidence of instability, infection, or trauma. There is no spondylolisthesis. There is no indication for decompression, given the lack of specific neurological findings. Physical examination provided by Dr. is insufficient, as the normals are not provided. One does not know whether the "weakness" of the quadriceps is pain related or is physiological in the absence of any normal response.

Based upon the failure of objective findings on imaging and the criteria of the ODG, the requested inpatient lumbar laminectomy with fusion at L2-L3 with a one day length of stay is not appropriate. Therefore, the previous adverse determinations are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- [ ] ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- [ ] 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)