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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/19/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

T9 to L4 fusion with removal of L4-S1 instrumentation and new instrumentation to the pelvis from the T9 level

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:

- 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.

T9 to L4 fusion with removal of L4-S1 instrumentation and new instrumentation to the pelvis from the T9 level - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. on 05/26/04, 08/13/04, 09/01/04, 05/29/08, 10/22/09, 02/25/10, 03/09/11, 05/06/11, 06/09/11, and 08/31/11

An operative report from M.D. dated 08/20/04
A consultation note from M.D. dated 08/23/04
An emergency room consultation note from an unknown provider (no name or signature was provided) dated 08/24/04
A Medication Review dated 05/18/11 from M.D.
An undated discharge summary from an unknown provider
A fax requesting a T9 to L4 fusion dated 06/03/11
A Notification of Determination from M.D. dated 06/08/11
A Utilization Review Referral from Dr. dated 07/13/11
Another Notification of Determination from M.D. dated 07/20/11
The Official Disability Guidelines (ODG) were not provided by the carrier/URA

PATIENT CLINICAL HISTORY

Dr. evaluated the patient on 05/26/04 and a Synergy battery replacement was recommended for 06/14/04. The patient underwent removal of spinal cord stimulator leads and neuro-generator. On 09/01/04, Dr. noted the patient had developed an abdominal wall cellulitis and an abscess. The system was emergently removed three days later and he was being followed by Dr. for IV antibiotics. His pain was well controlled with MS Contain. On 05/29/08, the patient informed Dr. his back pain was not improved at all. The patient continued with significant back pain with some pain in his lower extremities. Straight leg raising was negative for radiculopathy. Range of motion was limited in the lumbar spine. He was asked to return on a yearly basis, as Dr. did not feel he needed to return any sooner. Dr. stated on 02/25/10 that the patient continued to have pain in the back that was partially caused by the degenerative arthritis in both knees, which was noted to not be a part of his workers' compensation case. On 03/09/11, the patient stated his pain stimulator was no longer effective as it was when it was first put in. X-rays that day showed a solid fusion of L4 to the sacrum and he had significant changes above that. Hypertrophic osteophytes were noted at T12-L1, L2-L2, and L2-L3. Dr. stated he believed the patient's current back pain he was experiencing was related to increased stress on the lumbar spine as a result of the previous surgery. Dr. recommended a fusion from T9 to L4. The patient returned to Dr. on 05/06/11. He had not heard about the recommended surgery from the carrier and Dr. noted he felt the patient required, as a matter of medical necessity, an extension of his fusion. He noted the patient had broken down the adjacent segments to his L4-S1 fusion and he had developed fairly significant disc degeneration. On 06/08/11, Dr. provided an adverse determination for the requested surgical procedure. On 06/09/11, Dr. noted they had undergone multiple prolonged discussions regarding treatment options and the patient understood the requested surgery was the best option for him. Dr. again stated he felt the need for the surgery was directly related to the previous surgery at L4-S1. On 07/20/11, Dr. also provided an adverse determination for the requested surgical procedure. The patient informed Dr. on 08/31/11 that his surgery was being denied; however, he was in the IRO process. He continued with severe pain and discomfort in the back and had an antalgic gait with difficulty walking. The patient was asked to return in six weeks.

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

The patient has failed to receive relief of his pain from the original spinal surgery performed. His pain was so bad that he required a spinal cord stimulator, although one attempt at the spinal cord stimulator was actually infected and needed to be removed. The patient came under the care of Dr. The patient's pain increased to the point where he needed to use his spinal stimulator to a higher level. Dr. noted significant degenerative changes with kyphosis of the spine with degenerative changes reaching up to the thoracic spine. Dr., without any documentation of conservative care, recommended a fusion from T9-S1. There is no evidence of a psychological evaluation. There is no evidence that the degenerative changes noted by Dr. are the source of the patient's pain and there is no evidence that the patient would respond to its treatment. The patient does not have the requirements of the Official Disability Guidelines (ODG) for fusion surgery, including trauma, instability, or infection. The degenerative changes themselves are not an indication in and of themselves for fusion surgery.

The patient had two utilization reviews performed. The first was performed by Dr., an orthopedic surgeon, on 06/08/11. The date of injury was noted to be xx/xx/xxxx. Dr. did not recommend certification, based upon the absence of clear documentation of recent comprehensive clinical evaluation that would specifically correlate with the diagnosis of radiculopathy. Dr. also noted that there was no documentation of conservative management and the absence of a psychological assessment. The second utilization review was by Dr. and likewise he concurred that the surgery should not be certified. Dr. opined that there was no evidence the hardware was a pain generator or that the imaging findings supported the subjective complaints. Also, there was no indication for which fusion was indicated such as instability. Based on these facts, Dr. did not recommend certification.

In my opinion, the two adverse determinations by the URA should be upheld. There is no medical necessity for fusion from T9-L4. There is no indication that the patient is psychologically fit for such surgery, not having had a psychological evaluation. Further, the patient has a remote injury and it is not clear that the patient would improve from this surgery. The risks of the surgery outweigh the benefits and as noted above, the patient does not meet the ODG criteria for surgery. Therefore, the requested T9 to L4 fusion with removal of L4-S1 instrumentation and new instrumentation to the pelvis from the T9 level is neither reasonable nor necessary and the previous adverse determinations, as noted above, should be 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
- 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)