

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Decompression at L1-2 and L2-3, lateral arthrodesis, removal of instrumentation, anterior lumbar arthrodesis, reduction of lumbar subluxation, replacement of spinal stimulator and posterior instrumentation

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

M.D., Board Certified Orthopedic Surgeon, Spine Surgeon

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

ODG Low Back
Pre-auth UR review 01/11/12
Appeal pre-auth UR review 01/18/12
Pre-authorization requests various dates
Office visit notes Dr. 01/03/12, 08/10/10 and 04/27/10
Office notes Dr. 09/29/08-12/06/11
MRI lumbar spine 11/23/11
Operative report 07/19/10 and 11/27/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female injured on xx/xx/xx. She has a history of lumbar radiculopathy and failed back surgery syndrome. She underwent revision surgery on 11/27/09. She underwent further revision surgery of the lumbar spine on 07/19/10. She complained of back pain radiating to the right leg. An MRI of the lumbar spine performed 11/23/11 revealed post-operative changes. At L3-4 bone graft material has been displaced posteriorly into the spinal canal resulting in mass effect on the thecal sac and right L4 nerve roots. Further surgical intervention including decompression at L1-2 to alleviate stenosis and take care of HNP at L2-3 was recommended. There was no collapse so this will not need to be arthrodesed. Hardware removal will be required bilaterally at L3 to S1 to extract the cage at L3-4 and repair pseudoarthrosis at present.

A UR review dated 01/11/12 determined the request for L3-S1 revision lumbar spine surgery, hardware removal, removal of displaced cage, exploration and repair to be non-certified as medically necessary. It was noted the claimant underwent multiple lumbar procedures on

11/27/09 including L2-3 decompression, instrumentation L4-S1, lateral arthrodesis L3-S1, anterior arthrodesis L2-4 and interspace revision L2-S1. On 07/09/10 the claimant underwent removal of EBI transmitter/electrode and right L3-4 arthrodesis. She complains of low back pain and left leg pain in the L5-S1 distribution on 11/11/11, with 3/5 strength in the left EHL and decreased sensation in the left L4 distribution. An MRI on 11/23/11 showed right lateral recess narrowing at L2-3 and posterior right displacement of bone graft at L3-4 with compression of the sac and right L4 root. L1-2 was normal. On 01/02/12 the claimant had back pain and right left pain. On exam she had decreased right knee jerk and weakness in the right psoas and quad. After discussing the case with Dr. it was noted that MRI report revealed no abnormality at L1-2 therefore there is no compression and no need for decompression. It was further noted that decompression of L2-3 was performed on 11/27/09 and is unclear as to why there needs to be repeat decompression performed at this level. MRI does mention lateral recess narrowing on the right but is not clear if it is mild or significant. Furthermore there is virtually no clinical history provided to ascertain whether the claimant is symptomatic from nerve root compression and if so which root. Record on 11/11/11 states that claimant has left lower extremity pain, and record on 01/03/12 states the claimant has right lower extremity pain but there is no documentation of the pattern of the pain, distribution of the pain, frequency of pain, severity of pain etc. For surgery to be indicated there must be a thorough detailed history so there can be correlation of the history with exam and MRI findings. That is not the case here. According to OR note lateral arthrodesis was performed on 11/27/09. There is no documentation of subluxation to suggest failed arthrodesis so there is no need for this. Removal of instrumentation there is no documentation to suggest the need for removal. Anterior lumbar arthrodesis was already done on 11/27/09. There was no documentation of subluxation that would require reduction. It was noted there was no need for replacement of spinal stimulator as there is it was noted there was no documentation regarding good response from past stimulator to warrant another one.

An appeal UR review dated 01/18/12 again determined the proposed surgical procedure as non-certified. The reviewer concluded that reviewing old and recent records showed little in the way of any clinical corroboration as to true radiculopathy or hardware/end complaint complications. Dr. saw the claimant on 07/13/11 and noted the claimant had a history of lumbar radiculopathy and failed back surgery syndrome after lumbar surgery. Claimant was on pain medications and activities of daily living had improved. There was no "significant change from her last visit". On 11/11/11 the claimant had increased low back pain radiating down the left lower extremity in the L5-S1 distribution. The claimant complained of left lower extremity weakness with prolonged standing. On exam she had positive straight leg raise on the left, 4/5 strength in left EHL and decreased sensation in the left L4 distribution. The physician stated the claimant had new neurologic findings. Recent imaging does suggest L4 nerve root impingement but this is poorly corroborated on serial physical examinations. The recent medical shouldn't be acted upon urgently or emergently as this may multiply failed spine and should be corroborated over time or other objective means including electrodiagnostic studies.

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

Based on the clinical information provided, the request for decompression L1-2 and L2-3 with lateral recess arthrodesis, removal of instrumentation, anterior lumbar arthrodesis, reduction of lumbar subluxation, replacement of spinal stimulator and posterior instrumentation is not supported as medically necessary. Claimant has a history of previous multiple surgical procedures resulting in lumbar fusion L3 through S1. Claimant remains symptomatic and repeat MRI was performed on 11/23/11, which revealed posterior fusion hardware with bilateral pedicle screws of L3, L4 and S1. Graft material is noted at the L3-4 L4-5 and L5-S1 disc spaces. Susceptibility artifact from the hardware limits evaluation at these levels. Impression was reported as L3-4 bone graft material has been displaced posteriorly into the spinal canal resulting in mass effect on the thecal sac and right L4 nerve roots. Records indicate that on 11/11/11 the claimant complained of increasing amount of pain to the low back radiating down the left lower extremity, but subsequent evaluation by Dr. indicated claimant had complaints of back pain with radiation to the right leg. The extensive surgery

proposed including decompression at L1-2 and L2-3 is not supported by the records as there is no evidence of compression at either L1-2 or L2-3. There is evidence of displacement posteriorly of bone graft material at L3-4, but there is no indication that further assessment has been attempted to identify the pain generator either with selective nerve root block, or electrodiagnostic testing. The reviewer finds there is not a medical necessity for Decompression at L1-2 and L2-3, lateral arthrodesis, removal of instrumentation, anterior lumbar arthrodesis, reduction of lumbar subluxation, replacement of spinal stimulator and posterior instrumentation.

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)