

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient (IP) bilateral lateral transverse process fusion L3 to L4, posterior nonsegmental spinal fixation autograft from posterior iliac with three (3) day inpatient (IP) length of stay (LOS)

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

M.D., Board Certified Orthopedic spine surgeon, 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
Notice of utilization review findings 12/07/11
Notice of utilization review findings 01/02/12
Preauthorization request 11/25/11
CT lumbar spine without contrast 10/21/11 and addendum report
Office notes Dr. 10/29/10-11/28/11
X-rays lumbar spine 10/15/10
Operative report 10/15/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. He was lifting a compressor and strained his low back. He has a history of multiple surgeries including L2-5 fusion and artificial disc replacement L2-3. On 10/15/10 the claimant underwent additional surgery with removal of posterior segmental fusion L4-5, bilateral lateral transverse process fusion L5-S1, posterior segmental spinal fixation L4-S1, transforaminal lumbar interbody fusion L5-S1, prosthetic replacement L5 intervertebral disc, bone graft and left posterior iliac crest and local bone harvest. The claimant was seen on 10/07/11 with chief complaint of chronic low back pain. He was status post previous fusion, now with transforaminal lumbar fusion of L5-S1. X-rays performed on this date revealed instrumentation of L2-S1 appears to have adequate fusion. Hardware is in place with adequate arthrodesis. The patient was referred for CT scan of lumbar spine to verify fusion. CT scan performed 10/21/11 revealed postoperative changes, and per addendum report there is fracture running horizontally through the bone graft at L2-3 resulting in severe arthrosis at this level. There is horizontal fracture running through bone graft at L3-4 also resulting in pseudoarthrosis. The claimant was seen in

follow-up after undergoing CT scan. Bilateral lateral transverse process fusion L3-4 was recommended.. The claimant was seen on 11/28/11 with diagnosis of pseudoarthrosis L3-4. He continues to have pain and discomfort in his back. It is noted the claimant needs posterior fusion with instrumentation at L3-4. If there is significant amount of stability from anterior portion of procedure then may be possible to perform fusion without instrumentation.

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

This claimant has a history of multiple surgical procedures resulting in fusion of lumbar spine from L2-5. He underwent revision surgery including transforaminal lumbar interbody fusion L5-S1. He continued to complain of pain and discomfort in his back. Physical examination performed on 10/07/11 reported well healed surgical incisions. There is no infection. Strength was 5/5 except bilateral iliopsoas 4+/5 with give way and low back pain. Deep tendon reflexes were 2/4. Gait is steady but antalgic. CT scan of lumbar spine was performed on 10/21/11 and according to amended report there is fracture running horizontally through bone graft at L2-3 as well as horizontal fracture running through bone graft at L3-4 resulting in pseudoarthrosis. Dr. noted pseudoarthrosis is anterior. He noted definite crack in bone mass in one chamber of cage, and second chamber has what appears to be absolutely no bone. Both chambers at L2-3 level contain bone and one chamber is completely solid. Noting that the claimant has ongoing low back pain with objective evidence of pseudoarthrosis at L3-4 level, the reviewer finds that Inpatient (IP) bilateral lateral transverse process fusion L3 to L4, posterior nonsegmental spinal fixation autograft from posterior iliac with three (3) day inpatient (IP) length of stay (LOS) is medically necessary.

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)