

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (361) 226-1976
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/5/S1 TLIF w/posterior spinal fusion L4/5/S1 and spinal monitoring w/5days LOS

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

M.D., Board Certified Orthopedic Surgeon
Spinal 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, Low Back Chapter
Adverse determinations 11/04/11, 11/15/11
Preauthorization request 10/21/11
Office visit notes Dr. 06/22/11-10/19/11
Report of impairment rating and maximum medical improvement Dr. 04/05/11
Follow-up report Dr. 05/20/10-02/14/11
Presurgical psychological evaluation Dr. 08/23/11 (report date 10/04/11)
Lumbar myelogram and CT 06/14/10
Chiropractic progress notes Dr. 04/12/10-04/25/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx when he fell down a flight of stairs. He sustained injuries to neck, low back, and bilateral knees. MRI of lumbar spine from 11/20/09 revealed disc protrusion at L4-5 and L5-S1 with mild right neural foraminal narrowing at L4-5 and moderate left foraminal narrowing at L5-S1. He had surgery of the bilateral knees. He continued to complain of low back pain and left leg pain. CT myelogram performed on 06/14/10 reported disc narrowing, spondylosis, retrolisthesis exacerbated in extension and hard soft disc protrusion asymmetric toward the left at L5-S1 producing mild ventral dural deformity, slight retro displacement of proximal left S1 root sleeve and left lateral recess and foraminal narrowing. A right foraminal hard and soft disc protrusion is noted at L4-5 impinging upon the exiting right L4 nerve root sleeve in the foramen. There is also a left foraminal disc protrusion at T11-12. Facet joint arthrosis is most advanced on right at L4-5 and also present on the left at L4-5 and on right at L5-S1. At exam by Dr. on 11/19/11 he stated his low back pain is always present and comes and goes in intensity. He has had physical therapy for several months involving active exercising and passive modalities as

well. He had epidural and facet injections. The claimant stated epidural injections helped the most. He has had psychological evaluation that concluded there were issues of depression and several sessions of therapy were requested to establish the claimant's candidacy for surgery. He has seen Dr. who concluded the claimant is cleared for surgery. The claimant was noted to have failed all nonoperative treatments including therapy and injections and is recommended to undergo surgical intervention.

A preauthorization determination dated 11/04/11 determined that the request for L4-5-S1 TLIF with posterior spinal fusion L4-5-S1 and spinal monitoring 5 day LOS is not indicated as medically necessary. It was noted on review the claimant was injured when he fell down a flight of stairs at work.

The claimant stated he has undergone therapy, which helped. He stated he has undergone two epidural steroid injections, which helped for about a week. Previous MRI demonstrated hard and soft disc protrusions at L5-S1 on left with disc space narrowing, spondylosis and retrolisthesis exacerbated by extension. At L4-5 there is a right foraminal hard and soft disc protrusion impinging on the exiting right L4 nerve root sleeve. Facet arthrosis was noted bilaterally at L4-5 and L5-S1. Claimant is also noted to have had lumbar facet blocks in the past, which made his pain worse at first and then he got better for a few weeks. On exam facet signs are positive. Motor strength is 5/5 in the lower extremities. Straight leg raise is positive on the left at 45 degrees and on the right at 45 degrees. Both of these reproduce back pain. Deep tendon reflexes are 1+ in the lower extremities symmetrically and bilaterally. On 10/04/11 the claimant underwent pre-surgical psychological evaluation, which revealed there were no contraindications to surgery. On 10/19/11 claimant returned to clinic at that time he continued to have low back pain and lower extremity pain. Motor exam revealed muscle strength to be 5/5 throughout bilaterally. Lower extremity sensation was normal. Straight leg raise was negative bilaterally. The reviewer determined that the proposed surgical procedure was not indicated as medically necessary as the claimant has normal sensation, normal reflexes and normal muscle strength throughout. It was noted there were no imaging studies submitted for review to indicate any pathology in the lumbar spine or correlation physical examination. Current guidelines indicate there should be positive imaging studies and that these should correlate with a physical examination. As imaging studies have not been provided for this review the request does not meet current guidelines and is non-certified. It is noted the claimant has low back pain with no radicular symptoms and imaging studies have not been provided for review therefore request is non-certified.

A pre-authorization determination dated 11/15/11 determined that the claimant does not meet current Official Disability Guideline criteria for spinal fusion surgery. The claimant has an imaging study on 06/14/10 that shows disc extrusion towards the left at L5-S1 producing mild ventral dural deformity. There is also a slight retro displacement of the proximal left S1 nerve root. At L4-5 there is hard and soft disc protrusion impinging on the exiting right nerve root sleeve in the foramen. There is also left foraminal disc protrusion at T11-12. Examination dated 04/25/11 showed the claimant has diminished reflexes on the left side. He is able to heel and toe walk without difficulty indicative of good strength. Psychosocial evaluation has not been provided for this review. Current physical examination has not been provided for this review as the most recent physical examination was 04/25/11. As such the request is not considered reasonable and necessary at this point. An addendum to the report noted that additional clinical data was received including psychological evaluation dated 10/04/11 but there was still no current physical examination for review. As such medical necessity was not established.

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

This patient is noted to have sustained an injury when he fell down a flight of stairs. He was treated conservatively with physical therapy, medications and epidural steroid injections without significant improvement. He also underwent facet blocks without benefit. CT myelogram revealed disc protrusions at L4-5 and L5-S1. At L4-5 there is impingement of the exiting right L4 nerve root sleeve. At L5-S1 there was disc space narrowing, spondylosis and retrolisthesis exacerbated by extension. The claimant has been cleared from a psychological

perspective for surgery. Examination on 10/19/11 reported normal heel toe reciprocal gait. The claimant was able to heel and toe walk. Motor exam was 5/5 throughout the bilateral lower extremities. Deep tendon reflexes were 3/3 throughout the bilateral lower extremities. Babinski was negative. Clonus was negative. Sensation was normal. Straight leg raise was negative. There is an indication that retrolisthesis is exacerbated in extension, there is no quantification of the extent of listhesis at the L5-S1 level. The reviewer finds medical necessity is not established for L4/5/S1 TLIF w/posterior spinal fusion L4/5/S1 and spinal monitoring w/5days LOS.

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)