SENT VIA EMAIL OR FAX ON
May/31/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Anterior Discectomy Interbody Fusion, Posterior Decompression @ L5/S1 with 3 days Inpatient Hospital Stay

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Cover sheet and working documents
EMG/NCV report 10/02/07
Cervical MRI with 3D 07/29/08
Lumbar MRI with 3D 08/20/08
Orthopedic consult, follow-up notes, and x-ray reports M.D. dated 07/10/09-03/16/12
BHI2 test dated 09/23/09
Numerous court documents dated 02/12/10-03/28/12
Post designated doctor required medical examination dated 07/16/10
Computerized muscle testing (CMT) and range of motion (ROM) 08/03/10
Surgical pathology report dated 08/25/10
Report of medical examination dated 09/29/10
Functional capacity evaluation dated 10/06/10
Notice of IRO decision dated 10/20/10, 06/23/11, and 01/20/12
Required medical examination dated 07/14/11

Left shoulder MRI dated 08/23/11
Left shoulder MRI dated 08/23/11
Operative report dated 11/16/11
Lumbar MRI with and without contrast dated 03/05/12
Muscle strength exams dated 03/16/12 and 05/04/12
Surgery reservation sheet
Adverse determination letter amended 04/17/12
Adverse determination letter dated 05/08/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male for the City of who was injured secondary to motor vehicle accident on xx/xx/xx when motorcycle he was riding collided with another vehicle that turned in front of him. Records indicate the claimant sustained injuries to neck, shoulder, and low back. Per contested case decision and order of 09/28/11 it was determined the claimant is entitled to lumbar laminectomy and foraminotomy at L5-S1. Surgery was performed on 11/16/11. The claimant was seen postoperatively on 11/21/11. He presents with low back pain rated 8/10. Lower extremity symptoms have decreased in nature. X-rays were obtained and revealed no bony abnormalities and no fractures. There was foraminal space open as compared to previous x-rays. Plan was to begin aggressive physical therapy program for lumbar spine. The claimant was seen in follow-up on 01/04/12 for follow-up on neck, back and left shoulder injuries. The claimant states he is currently participating in physical therapy and back is better than preoperative. Back pain is 3/10. He gets occasional radiation to left leg. He is happy with neck and states neck is asymptomatic. His concern now is primarily with left shoulder. Impression was status post ACDF C5-6 and C6-7; status post lumbar laminectomy L5-S1; left longhead biceps tendon rupture. Follow-up on 02/16/12 noted the claimant has participated in and completed at home physical therapy for lumbar spine. In past week or so he noticed increased pain in low back area. He stated he has difficulty with various movements and has lower extremity symptoms that include numbness and tingling and weakness. He also complains of left shoulder pain. Examination of lumbar spine indicates tenderness from mid to lower lumbar region with decreased range of motion with flexion / extension. He continues to experience diminished sensation along left L5 distribution of lower extremities. There is weakness noted in knee flexors and extensors. Reflexes are symmetric. MRI of lumbar spine on 03/05/12 reported L5-S1 annular disc bulge and bilateral facet osteoarthritis causing moderate bilateral lateral recess narrowing and mild central canal stenosis. The neural foramina show moderate severe encroachment. The exiting L5 nerve root sheaths bilaterally are contacted. There are changes from remote bilateral laminectomy at this level. There is enhancing epidural fibrosis dorsal to thecal sac and into region of lateral recesses bilaterally. Moderate canal stenosis is noted at L4-5 secondary to spondylosis annular disc bulges and bilateral ligamentum flavum hypertrophy. Spinal canal at L3-4 is borderline stenotic on developmental basis. The claimant was seen on 03/16/12 for follow-up on neck and back injuries. He currently complains of 7/10 lumbar pain. He also complains of weakness in left shoulder and difficulty getting arm behind back. According to Dr., lumbar MRI on 03/05/12 showed complete collapse and disc herniation at L5-S1 with disc herniation and bilateral foraminal stenosis. On examination there was diminished sensation along the left L5 distribution but lower extremity motor strength is intact. The claimant was recommended to undergo anterior interbody discectomy and interbody fusion.

A preauthorization review for anterior discectomy and interbody fusion, posterior decompression L5-S1 with 3 day inpatient hospital stay was reviewed on 04/16/12 by Dr. who recommended non-authorization. It was noted the claimant had decompressive surgery performed on 11/16/11 which allegedly did foramen enlargement; however, the recent MRI on 03/15/12 showed osteophytes and foraminal narrowing residuals. Moreover, the L4-5 level has now size of 7 mm and L3-4 level is interpreted by radiologist to be borderline stenotic. There was reference to the claimant using tobacco products but this was not clearly discussed by Dr.. Any fusion procedure at L5-S1 will create increased stresses at the adjacent levels which are already abnormal. Thus the requested surgery is not approved.

There is no instability or evidence of fracture noted in the imaging studies.

A reconsideration request was reviewed by Dr. on 05/08/12 and he recommended non-authorization for anterior discectomy interbody fusion, posterior decompression at L5-S1 with three day inpatient hospital stay. It was noted that the claimant underwent right total hip replacement in 02/09, followed by anterior cervical discectomy and fusion C5-6 and C6-7 in 08/10 followed by another surgical intervention of 11/16/11 for lumbar laminectomy with foraminotomy bilaterally at L5-S1. MRI of the lumbar spine on 03/05/12 revealed lateral recesses at L5-S1 were narrowed secondary to osteophytes, annular disc bulging, bilateral facet arthrosis and epidural fibrosis. Old L5-S1 surgical changes were seen. Central canal at L5-S1 was mildly stenotic. There was moderately severe L5-S1 foraminal encroachment bilaterally with impingement on the exiting L5 nerve root sheaths bilaterally. Moderate canal stenosis at L4-5 was secondary to spondylosis, annular disc bulging and bilateral ligamentous ligamenta flava hypertrophy. Dorsal epidural fat also contributed to the canal narrowing at L4-5. The neural foramina at L4-5 were mild mildly to moderately stenotic with compressing without compressing the exiting L4 nerve root sheaths. Spinal canal at L3-4 was borderline stenotic on a developmental basis. The neural foramina at L3-4 were mildly encroached bilaterally. There was no significant canal or foraminal stenosis at L1-2 or L2-3. On evaluation dated 03/16/12 the claimant stated he had done three courses of physical therapy. He reported lumbar pain rated 7/10 on VAS. He also complained of weakness in the left shoulder and difficulty getting his arm behind his back. Examination of the cervical spine revealed range of motion was only mildly diminished. Elbow strength sensation was intact. Left upper extremity motor strength was slightly diminished in elbow flexion but claimant did have difficulty bringing his arm back in extension and internal rotation behind his body. Claimant had diminished sensation along the left L5 distribution but motor strength was intact. Per clinician it appeared that the simple decompression alone was not able to address the claimant's back pain and neurogenic claudication mostly due to significant collapse at L5-S1. Electrodiagnostic studies from 10/02/07 reported findings consistent with bilateral L5 nerve root compression with left side being affected greater than the right as well as left side nerve root irritation. It was noted that MRI of 03/05/12 showed osteophyte and foraminal narrowing residuals at L5-S1. Moreover the L4-5 the L4 level has a canal size of 7mm and the L3-4 level is interpreted as borderline stenotic. It was noted that the claimant using tobacco products was not clearly discussed. Any fusion surgery at L5-S1 would create increased stress at the adjacent levels which are already abnormal. The request for surgery is not approved and there is no instability or any evidence of fracture noted in the imaging studies. The claimant has no documented lumbar instability by imaging. Criteria also states all pain generators have been identified and treated. There's no documentation of a lumbar epidural steroid injection. There's no recent documentation of any anti-inflammatory muscle relaxers. Claimant has had no psychosocial screen with confounding issues addressed. Given the current clinical data, non-certification was recommended.

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

Medical necessity is not established for the proposed anterior discectomy interbody fusion, posterior decompression at L5-S1 with three day inpatient hospital stay. The claimant is status post L5-S1 lumbar laminectomy, foraminotomy bilaterally performed 11/16/11. He continued to complain of low back pain with diminished sensation along left L5 distribution. Lower extremity motor strength was intact. MRI of lumbar spine on 03/05/12 revealed postoperative changes at L5-S1, with narrowing of lateral recesses secondary to osteophytes, annular disc bulging and bilateral facet arthrosis, and epidural fibrosis. The central canal at this level is mildly stenotic. There is moderately severe L5-S1 foraminal encroachment bilaterally with impingement on exiting L5 nerve root sheaths bilaterally. Dr. states the MRI shows complete collapse at L5-S1 but this is not indicated on radiology report. There was no evidence of motion segment instability as documented by flexion / extension views. Also as noted on previous reviews, no presurgical psychological evaluation addressing confounding issues was documented. Given the current clinical data, medical necessity is not established for proposed surgical procedure, and the previous denials are upheld.

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

[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)