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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

360 Degree Lumbar Fusion at L4-5, Lumbar Laminectomy @ Bilateral L4-5, insert Spinal Fixation Device, Apply Spinal Prosthetic Device, Removal of Spinal Lamina Add-On, Removal of Spinal Lamina Add-On, Spinal Bone Allograft, Inpatient Hospitalization 2 Days

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

M.D., Board Certified Orthopedic spine 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

ODG-TWC Treatment Guidelines

Past medical records including MRI lumbar spine dated 01/09/03, MRI lumbar spine without contrast dated 09/29/09, progress note dated 05/22/10, and lab records dated 08/06/10

Employer's first report of injury or illness dated xx/xx/xx

Associate statement dated xx/xx/xx

Authorization for release of medical records and reports dated xx/xx/xx

Worker's compensation request for medical care dated xx/xx/xx

Notice of disputed issues and refusal to pay benefits dated 12/09/10, 04/08/11, and 05/08/11

Emergency department records dated xx/xx/xx

Handwritten progress notes dated 09/07/10-02/14/11

X-ray report dated 09/07/10

Initial evaluation and progress notes xxxxxx dated 09/16/10-02/15/11

Initial evaluation Health and Rehab and follow-up notes dated 02/18/11-01/25/12

Report of medical evaluation dated 03/03/11

Functional capacity evaluation report dated 03/03/11

Review of medical history and physical examination dated 03/07/11

MRI lumbar spine dated 03/21/11

MRI lumbar spine dated 03/22/11

Functional capacity evaluation dated 03/22/11

Initial interview for chronic pain management program dated 04/07/PhD

Office visit notes M.D. dated 04/14/11-02/21/12

Radiographic report lumbar spine 4 views dated 05/13/11

Office visit notes M.D. dated 06/13/11-01/16/12
Office visit notes dated 08/24/11-10/11/11
Report of medical evaluation / designated doctor evaluation dated 09/30/11
Presurgical consultation and behavioral assessment dated 03/22/12
NOVARE References for screening criteria
Chronic pain management progress reports sessions 1-6 dated 04/02/12-04/17/12
Utilization review determination dated 04/04/12
Utilization review determination dated 04/19/12
Summary rationale for IRO dated 05/15/12
IRO summary dated 05/16/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who injured her low back while lifting a box off a pallet on xx/xx/xx. She is noted to complain of low back pain radiating to right lower extremity. There are two MRI scans which predate the date of surgery included, with MRI dated 01/09/03 revealing minimal degenerative change and small posterior disc protrusion at L5-S1 and associated degenerative change of L4-5 disc. There is also MRI dated 09/29/09, which revealed transitional vertebra labeled at L5. At the level designated L4-5 there is mild broad based posterior protruding disc and annular tear which contacts both L5 nerve roots and produces mild bilateral foraminal stenosis without significant central spinal stenosis at this or any level of lumbar spine. MRI of lumbar spine performed 03/21/11 reported lumbar spondylosis involving L4-5 disc space. There is central and paracentral disc protrusion at L4-5 with obliteration of epidural fat and impingement on the thecal sac and right L5 nerve root. There is no evidence of spinal stenosis and no evidence of spondylolysis and spondylolisthesis. X-rays of lumbar spine on 05/13/11 reported touch of scoliosis of lumbar spine towards the left side with degenerative disc disease involving the entire lumbar vertebral disc spaces more marked at L5-S1. There was no evidence of spondylolisthesis or retrolisthesis on flexion / extension views. Records indicate the claimant was treated conservatively with medications including NSAIDs, Hydrocodone, Gabapentin, and Diclofenac. She also was treated with physical therapy, traction and massage. Epidural steroid injection was noted to provide temporary relief of pain. A presurgical and behavioral assessment dated 03/22/12 determined the claimant was psychological stable to undergo any surgical intervention found necessary for success of claimant's recovery.

A preauthorization request for 360 lumbar fusion at L4-5 with bilateral laminectomy was reviewed on 04/04/12 and the request was determined as not medically necessary. The reviewer noted the claimant is an obese female who sustained what appeared to be rather significant lifting injury. MRI documents L4-5 disc desiccation with central high signal intensity and possible L5 nerve root impingement. She has had physical therapy, epidural steroid injection, and multiple narcotic and non-narcotic medication trials without long-term success. It was noted there was no EMG/NCV or flexion / extension x-rays. Smoking history is unknown. She has radicular pain and one examiner documents grad 3-4/5 motor loss in bilateral dorsiflexors. Wide lumbar decompression is proposed followed by fusion to ensure spinal stability, which is anticipated to be compromised with wide decompression. ODG criteria for lumbar fusion indicate it is poor choice for those using chronic narcotics, those with obesity, smokers, and for those with greater than 6 months of disability. Fusion is not indicated for radiculopathy, but rather primary low back pain in the face of documented segment instability. The claimant does not meet these criteria, nor does she meet the criteria for unequivocal radiculopathy described in Official Disability Guidelines. As such, the claimant would appear to be poor surgical candidate, and denial was recommended.

A reconsideration / appeal request was reviewed on 04/19/12, and again, the request was recommended as non-certified. The reviewer noted that the records included reference to 03/22/12 psychological review. Nowhere in medical information was inclusion or reference of electrodiagnostic studies or flexion / extension x-rays. It was noted the claimant is a poor operative candidate especially for fusion without demonstrable instability, tumor or infection noted. At most the claimant has isolated radiculopathy, which, might be a limited

decompression. At this point no selective nerve root block or electrodiagnostic studies had been performed to confirm the issues in question.

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

The claimant sustained a lifting injury to the low back on xx/xx/xx. There is no explanation as to why the claimant underwent MRI studies of the lumbar spine prior to the date of injury in this case with initial MRI dating back to 2003. The claimant was treated conservatively with medications, physical therapy, and epidural steroid injection without resolution of symptoms. MRI of the lumbar spine on 03/21/11 revealed central and paracentral disc protrusion at L4-5 with impingement of the thecal sac and right L5 nerve root. There was no evidence of spinal stenosis and no evidence of spondylolysis or spondylolisthesis. Flexion extension x-rays showed no evidence of motion segment instability at any level of the lumbar spine. The ODG criteria is not satisfied. The reviewer can find no medical necessity for the extensive surgical procedure proposed. The reviewer finds that there is not medical necessity for 360 Degree Lumbar Fusion at L4-5, Lumbar Laminectomy @ Bilateral L4-5, insert Spinal Fixation Device, Apply Spinal Prosthetic Device, Removal of Spinal Lamina Add-On, Removal of Spinal Lamina Add-On, Spinal Bone Allograft, Inpatient Hospitalization 2 Days.

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)