

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient surgery LOS 2 days/Anterior lumbar interbody fusion @ L4-5 and L5-S1, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation @ L4-5 and L5-S1

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 Low Back Chapter
Preauthorization review 01/11/12
Reconsideration of utilization review determination 01/20/12
Neurologic surgery consultation notes Dr. 10/20/11 and 07/25/11
Prior authorization request 12/14/11
Prior authorization appeal request 01/12/12
Letter of reconsideration 01/12/12
Lumbosacral spine x-rays for flexion / extension lateral bending views 11/10/11
Presurgical and behavioral medicine consultation 11/17/11
Physical therapy initial evaluation and progress notes 04/19/11-06/22/11
MRI scan lumbar spine 08/01/11
MRI lumbar spine 07/06/11
Progress notes Dr. 10/12/11
Operative report bilateral S1 epidural steroid injection 09/14/11
Pain management consultation Dr. Shah 08/08/11
CT myelogram lumbar spine 10/13/11
Summary letter for independent review 02/09/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is noted to have sustained injury to low back on xx/xx/xx while changing tires on large truck. He reportedly completed balancing a tire, and when he mounted the tire on truck felt something snap in his back. The claimant was initially diagnosed with lumbar sprain / strain and prescribed medications and physical therapy. MRI lumbar spine on 07/06/11 revealed left lateral disc protrusion at L2-3 contacting exiting left L2

nerve root; central disc bulge at L4-5 indenting the ventral thecal sac without significant canal stenosis; osteophyte / disc complex L5-S1 contacts exiting L5 and descending S1 nerve roots. Surgical changes of left laminotomy were identified at L5-S1. High point intense signal and left anterolateral recess may represent scar tissue, recurrent HNP cannot be excluded. Repeat MRI with contrast performed 08/01/11 revealed an infrarenal abdominal aortic aneurysm measuring 3.3 x 3.4 cm in transverse and AP dimension. This is unchanged compared to prior study of 07/06/11. At L4-5 there is broad based central disc protrusion and bilateral facet and ligamentum flavum hypertrophy causing mild spinal stenosis with no significant foraminal stenosis. At L5-S1 there has been previous left sided laminotomy and discectomy. There is diffuse posterior disc osteophyte complex slightly more prominent to left side and bilateral facet arthropathy. This causes mild to moderate left sided foraminal stenosis and mild right-sided foraminal stenosis. No spinal stenosis is seen at this level. Previous report described left far lateral disc protrusion at L2-3, which is not reproduced on current MRI scan. CT myelogram was performed on 10/13/11 and revealed broad based approximately 4 mm disc protrusion at L4-5 resulting in mild spinal stenosis. There is severe spondylosis most significant at L5-S1 where there is retrolisthesis and foraminal stenosis. Flexion / extension x-rays performed 11/10/11 revealed multilevel degenerative disc disease and spondylosis more severe at L5-S1, with limited range of motion on flexion / extension and lateral bending maneuvers. Records indicate the claimant underwent epidural steroid therapy without significant improvement in symptomatology.

A utilization review determination dated 01/11/12 determined the request for anterior lumbar interbody fusion at L4-5 and L5-S1 with posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 and L5-S1 as not meeting medical necessity guidelines. Reviewer noted that the claimant sustained an injury to the low back on 02/25/11. He was treated conservatively with medications, therapy and epidural steroid injections without significant improvement. Imaging studies reveal multilevel degenerative changes. There was evidence of previous left sided laminotomy and discectomy at L5-S1. A diffuse posterior disc osteophyte complex was noted at this level slightly more prominent to the left side with bilateral facet arthropathy, which caused mild to moderate left sided foraminal stenosis and mild right-sided foraminal stenosis, but no central spinal stenosis. At L4-5 there is a broad based central disc protrusion with bilateral facet and ligamentum flavum hypertrophy causing mild spinal stenosis but no significant foraminal stenosis. There was no evidence of motion segment instability on flexion extension views. Given the current clinical data, the proposed surgical procedure was not recommended as medically necessary.

A reconsideration request for anterior lumbar interbody fusion at L4-5 and L5-S1 with posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L4-5 and L5-S1 was reviewed on 01/20/12 and previous denial was upheld. It was noted that the claimant's MRI/x-rays showed mild canal stenosis without foraminal stenosis at L4-5. There was no documented nerve root compression to warrant decompression at this level. Furthermore there was no documented instability, subluxation, fracture to warrant fusion at this level. In addition there was no thorough documented history regarding the claimant's pain. The claimant had low back pain, left lateral thigh and calf pain and "increasing RLE pain". There is no detail regarding the frequency of the left leg pain. There is no detail regarding the frequency, distribution, pattern, severity, etc. of the right leg pain. It was not clear if the right leg pain was in a particular nerve root distribution and if so which root. For this reason his pain complaints cannot be correlated with any radiographic findings. The L5-S1 surgery is not appropriate. There is only mild right foraminal narrowing so it is not clear that right L5-S1 decompression is indicated.

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

This claimant sustained injury to the low back on xx/xx/xx. His condition was refractory to conservative care including medications, therapy and epidural steroid injections. Imaging studies revealed multilevel degenerative changes, with post-operative changes noted at L5-S1 where a previous left sided laminectomy laminotomy and discectomy had been performed. At L4-5 there is a broad based central disc protrusion with bilateral facet and ligamentum flavum hypertrophy causing mild spinal stenosis but no significant foraminal

stenosis. At L5-S1 a diffuse posterior disc osteophyte complex, which is slightly more prominent to the left side in combination with bilateral facet arthropathy causes mild to moderate left sided foraminal stenosis and mild right sided foraminal stenosis, but no central canal stenosis at this level. There was no evidence of motion segment instability on flexion extension views of the lumbar spine. Claimant was cleared for surgical intervention from a psychological perspective. However, noting a lack of significant neurocompressive pathology at L4-5, and further noting the lack of instability of the lumbar spine at any level, the reviewer finds medical necessity is not established for the proposed Inpatient surgery LOS 2 days/Anterior lumbar interbody fusion @ L4-5 and L5-S1, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation @ L4-5 and L5-S1.

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)