

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

Signed electronically on: Nov/05/2012

DATE NOTICE SENT TO ALL PARTIES:

Nov/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2-3 day inpatient surgical procedure of 360 L4/S1 with ICBG and L2/S1 Decompression

A 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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy notes 03/11/11-08/30/12
Rush peer review addendum 08/27/10
Designated doctor evaluations 01/07/11-08/30/11
Procedure note dated 09/21/10
Radiographs lumbar spine 06/18/10
MRI lumbar spine 07/29/10
Clinical note 09/18/10
Clinical notes 05/10/11-10/20/12
Radiographs lumbar spine 05/10/11
CT myelogram lumbar spine 07/20/11

Clinical notes 05/29/12-06/29/12
Consult from 09/19/12
Pre-surgical psychological evaluation 09/21/12
Prior reviews 10/02/12 and undated review
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury after picking up a lawnmower. The patient developed pain in the low back and shoulder. MRI or radiographs of the lumbar spine on 06/18/10 revealed grade 1 anterolisthesis of L4 on L5 and retrolisthesis of L3 on L4 that was degenerative in nature or degenerative in origin. No spondylolytic defects were demonstrated. MRI of the lumbar spine on 07/29/10 revealed moderate canal stenosis at L2-3 and mild canal stenosis at L3-4 secondary to disc osteophyte complexes. Previously noted grade anterolisthesis at L4 on L5 was present with uncovering of the superior disc margin. Moderate to severe central canal stenosis was present with possible encroachment on the descending bilateral L5 nerve roots. Moderate to severe left worse than right foraminal stenosis at L4-5 is present. At L5-S1 there was disc space loss and narrowing of the bilateral subarticular recesses contributing to severe foraminal stenosis bilaterally. No canal stenosis at L5-S1 was present. The patient did undergo epidural steroid injections in 2010 and the patient was recommended for lumbar fusion. This was subsequently not recommended by several designated doctor evaluations. Flexion extension views of the lumbar spine in 05/11 revealed anterior subluxation of L4 on L5 at approximately 10mm with no instability present on flexion and extension views. CT myelogram studies were recommended in 06/11 and completed on 07/20/11. The pre-myelogram CT study revealed 2-3mm disc protrusions at L2-3 and L3-4 result in mild resulting in spinal stenosis resulting in no spinal canal stenosis at either level. There was mild to moderate foraminal stenosis noted at L2-3 and L3-4. At L4-5 there was a pseudo bulge posteriorly present to spondylolisthesis measuring 8mm in the transverse. There was facet joint arthropathy contributing to severe bilateral recess stenosis and there was moderate to severe foraminal stenosis present due to spondylolisthesis and facet arthropathy. A mild posterior disc osteophyte complex was present without evidence of spina canal stenosis. There was moderate to severe foraminal stenosis secondary to disc osteophyte complexes and facet joint hypertrophy. Following myelogram injection the CT study revealed continuing grade 1 spondylolisthesis at L4-5 that was previously noted. Mild ventral indentations were noted from T12 to L1 and L1 through the L5-S1 levels compatible with posterior disc protrusions. No critical canal stenosis was noted at any level. The patient did attend physical therapy through 08/12 and the patient was recommended for selective nerve root blocks in 05/12. These were performed on 06/15/12 which did not provide significant relief of patient's symptoms. The clinical evaluation by Dr. on 08/14/12 suggests that recent CT studies were completed and reviewed. No updated CT myelogram studies were provided after the 07/11 study. A clinical note from 09/19/12 indicated the patient was reluctant to undergo lumbar spinal fusion. The patient was continued on Celebrex, Parafon Forte, and Tylenol 3 as well as further epidural steroid injections. The patient underwent a psychological consult for pre-surgical evaluation on 09/21/12. Patient's BDI score was 18 and BAI score was 14. A low to moderate degree of fear avoidance beliefs were noted on FABQ testing. The patient again voiced hesitancy regarding the proposed surgical procedure. There was two noted medical risk factors for poor surgical outcomes to include which included highly destructive quality of the proposed fusion surgery and non-spine medical utilization. There was other minimal psychological risk factors for poor surgical outcome. The letter from Dr. dated 10/20/12 stated that the patient would require facetectomy at L5-S1 at L4-5 and L5-S1 causing iatrogenic instability necessitating lumbar fusion. The request for L4 through S1 fusion and an L1 through L5 decompression was denied by utilization review on 10/02/12 as there were no updated imaging studies and no indicated clinical reference regarding pain generators for the lumbar spine. The request was again denied by utilization review as there was no clear pathology above L4-5 requiring the requested surgical procedures and there was indications that the patient was not fully interested in surgical intervention.

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

The request for 360 degree L4 through S1 lumbar fusion with L2 to S1 decompression and a two to three day inpatient stay with ICVG is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines.

Upon review of the 07/11 CT myelogram studies there is limited evidence of any pathology above L4-5 that would reasonably require lumbar decompression. The CT myelogram study identified no evidence of significant spinal canal stenosis that would reasonably require decompression procedures from L2 to L4. No updated imaging studies have been provided for review since 07/11 and the clinical documentation does not specifically identify what pain generators are contributing to the patient's current symptomology. Given the wide surgical recommendations for the lumbar spine the surgery would not be consistent with guideline recommendations. Additionally there is noted hesitancy of the patient to even undergo the requested surgical procedures and given the lack of any updated imaging medical necessity would not be established at this time. As such the prior 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

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)