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Notice of Independent Review Decision Revised.

Date notice sent to all parties: 11/1/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-S1 360 degree fusion with L3-L5 Laminectomy.

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

Texas Licensed Orthopedic Surgeon.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X- Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Letter to IRO dated 10/20/12

2. MD office notes 8/6/12- /16/12

3. CT and myelogram of 4/30/12.

4. MRI 2/17/11

5. MRI 11/15/10

6. Pain management notes 2/11/11 –

7. MD notes 2/10/11 – 11/11/10

8. MD notes 12/29/10 - 1/20/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a man with history of low back injury .

He was lifting heavy material when he developed low back pain.

Medical records document lumbar MRI which predates injury date . This study showed mild central stenosis at L4-L5 with mild to moderate narrowing of right and left neural foramina a small left paracentral disk bulge is noted. There is mild bilateral neuroforaminal narrowing at L3-L4.

The medical records reflect that the claimant underwent lumbar transforaminal epidural steroid injection on 02/11/2011. This was performed at left L3, L4, and L5. He reported 80% relief of pain.

Because of persistent low back pain, a repeat lumbar MRI was performed on 02/17/2011. This demonstrated left paracentral disk herniation at L4-L5 and L5-S1 with moderate neural foraminal narrowing.

The medical records contain lumbar CT myelogram 04/30/2012 which demonstrated degenerative changes at L4-L5 and L5-S1. There was focal disk protrusion at L4-L5 impinging upon the exiting L5 nerve root. Slight impingement of the right S1 nerve root due to disk protrusion at L5-S1 was noted. There was anterolisthesis of L5/S1. This is noted on lateral flexion view. There is also anterolisthesis of L4/L5.

The radiology conclusion lists the following:

1. Degenerative disc disease involving L4-L5 disc space.

2. Diffuse disc bulge with central and paracentral disc protrusion at L4-L5 level with obliteration of epidural fat and impingement on both L5 nerve roots.

3. Focal disc protrusion on the right side at L5-51 level with slight impingement of right 51 nerve root.

4, Central spinal canal stenosis at L4-L5 level.

5. Facet hypertrophy and arthropathy on the right side at L5-S1 level with facet osteophyte formation on the right side as mentioned above.

6. Anterolisthesis of L4 vertebral body with reference to L5.

Dr. consequently recommended an extensive lumbar spinal fusion at multiple levels.

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

Unable to certify the medical necessity and appropriateness of multilevel L2-S1 360 degree fusion with L3-L5 Laminectomy. This is extensive surgery with little documentation to support recent trial of conservative management. Short and long term goals are not addressed. This type of back surgery is generally performed as a last resort in patients who have failed all other forms of conservative management.

There are unexplained findings noted such as a history of lifting injury but there is a lumbar MRI that was performed 2 weeks earlier . There are no other notes which predate the listed injury date however.

The claimant has undergone prior conservative care, but there is no recent physical therapy trial since January 2011 submitted for review. Often land or aquatic therapy is used as part of a chronic back pain management program but is not noted in the medical records reviewed. 6 months of physical therapy and supervised exercises should be documented prior to embarking on such extensive spinal fusion surgery. It is unknown what type of active rehab program that the claimant participates in or whether the claimant performs a self supervised home exercise program. In addition, the severity of low back pain is not particularly demonstrable on the basis of any abnormal physical examination findings. There is no indication that the claimant is requiring escalating doses of narcotics or analgesics for control of low back pain. The claimant reportedly had 80 percent relief with a lumbar epidural steroid injection but there are no other lumbar epidural steroid injections listed. It is unclear if the use of repeat lumbar epidural steroid injections in combination with adjustment of medications and an active spinal rehabilitation program could obviate the need for extensive spinal fusion surgery. This is not addressed.

Also, despite abnormalities seen on lumbar imaging suggestive of nerve root impingement, there are no emg / nerve conduction studies which document findings supporting lumbar radiculopathy. Also, there are no notes which document a trial of back bracing to treat any lumbar mechanical

instability related to spondylolisthesis. There is a significant difference of opinion between Dr. interpretation of the 4/30/2012 lumbar CT scan and radiologist Dr. There is no specific correlation of symptoms to these findings with regard to left sided versus right sided findings and the description of large disc herniation is nonspecific and not correlated with symptoms. There is no information that the clinical findings or objective physical examination findings or deficits have progressed over time.

ODG guidelines address lumbar spinal fusion and do not support spinal fusion in this case.

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X-DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

X-MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES