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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Anterior Lumbar Interbody Fusion at L4-5 and L5-S1, Posterior Lumbar Decompression With Appeal: Posterolateral Fusion and Pedicle Screw Instrumentation at L4-5 and L5-S1 with a 2 Day Inpatient Stay

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

M.D., Board Certified Neurological surgeon

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. The reviewer finds medical necessity is not established for the requested Inpatient Anterior Lumbar Interbody Fusion at L4-5 and L5-S1, Posterior Lumbar Decompression With Appeal: Posterolateral Fusion and Pedicle Screw Instrumentation at L4-5 and L5-S1 with a 2 Day Inpatient Stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

Legal correspondence dated 10/18/12

Request for IRO dated 10/18/12

Utilization review determination dated 10/09/12

Utilization review determination dated 10/17/12

Clinical note Dr. 05/21/12

CT lumbar spine dated 05/22/12

EMG/NCV study dated 07/05/12

MRI lumbar spine dated 07/06/12

Procedure report LESI L5-S1 08/17/12

Clinical note Dr. dated 08/27/12 and 10/20/12

Psychiatric evaluation dated 09/13/12

Radiographic report lumbar spine dated 09/27/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have developed low back pain with radiation into lower extremity while working. The first available clinical record is dated xx/xx/xx. The claimant is reported to have low back pain with weakness in legs and feet. MRI is reported to show disc protrusion at L4-5 with left foraminal stenosis and disc bulge at L5-S1 with severe bilateral foraminal stenosis. He is reported to have decreased sensation in left lower

extremity in L4-5 distribution with motor deficit involving left lower extremity.

The record includes CT of lumbar spine dated 05/22/12. This study shows no substantive abnormalities from T12-L1 through L3-4. At L4-5 there is a small posterior disc bulge with superimposed left paracentral disc protrusion. There is some indentation compromising the ventral aspect of subarachnoid space. Asymmetric left side greater than right. There is some extension of left lateral recess. This disc herniation may be in close proximity and perhaps touching L5 nerve root. There is some thickening and redundancy of ligamentum flavum. There is mild hypertrophy of bilateral facet joints. At L5-S1 there is small posterior broad based disc protrusion. There is a slight indentation compromise of ventral aspect of subarachnoid space. There is some thickening and redundancy of ligamentum flavum. There is mild hypertrophy of bilateral facet joints. Spinal canal appears relatively patent without definite spinal canal stenosis. There is mild neural foraminal stenosis at L4-5 and L5-S1 levels. The claimant was subsequently referred for EMG/NCV on 07/05/12. This study notes abnormalities suggestive of radiculopathy at L5-S1 levels bilaterally.

A repeat MRI of lumbar spine was performed on 07/06/12. This study notes disc desiccation and intervertebral joint space narrowing worse on L4-5 and L5-S1. At L4-5 there is a disc bulge with superimposed 6 mm left posterolateral foraminal disc protrusion. This effaces the far left lateral recess and contributes to left foraminal stenosis. The exiting left L4 nerve root is contacted in the foramen. The right foramen is patent. At L5-S1 there is a 2-3 mm disc bulge extending into the inferior aspect of foramen. There is facet hypertrophy. There is moderate to severe bilateral foraminal stenosis. The exiting L5 nerve roots are contacted in the foramen bilaterally. Records indicate on 08/17/12 the claimant underwent a lumbar epidural steroid injection at L5-S1.

On 08/27/12 the claimant was seen by Dr.. The claimant is reported to have low back pain with radiation of left lower extremity. He is reported to have undergone physical therapy and epidural steroid injections without significant improvement. The claimant's surgical history is pertinent for lap band procedure performed in 2011. On physical examination he is 6'2" 295 lbs. His lumbar range of motion is significantly reduced in forward flexion secondary to pain. He is reported to have 4/5 strength in left tibialis anterior, EHL, and gastrocnemius muscles. Reflexes are 2+ on left, otherwise 2+ throughout. He is reported to have marked difficulty with heel and toe walk. Straight leg raise is positive left greater than right. He is reported to have hyperesthetic regions in distribution of L4, L5 and S1 on left. The claimant was subsequently recommended to undergo anterior lumbar interbody fusion at L4-5 and L5-S1.

The record includes surgical psychological evaluation dated 09/13/12 in which the claimant was cleared to undergo surgical intervention. Lumbar flexion / extension radiographs were performed on 09/27/12. This study notes no pathological subluxation between flexion / extension radiographs.

The record contains a rationale provided by Dr. dated 10/20/12. He opines a traditional laminectomy will be ineffective in addressing the patient's complaints. He reported the only way to address this issue would be to perform facetectomy which would cause iatrogenic induced instability requiring fusion at that level. He reported fusion at L5-S1 level would transmit mechanical forces to L4-5 disc. He opines the L4-5 disc would not be able to support additional stressors as result of L5-S1 fusion. He opines it would be clinically appropriate to fuse L4-5 level as well.

The initial review was performed by Dr. on 10/09/12. Dr. non-certified the request noting no progressive neurologic deficit, tumor, infection or instability documented in the medical records. He notes there is neurocompressive lesion consistent with compression at 2 levels on left side. There is electrodiagnostic evidence of radiculopathy as well. MRI does not demonstrate significant degenerative changes or lateral recess stenosis but rather mild stenosis as well. He notes in discussion with physician he could not explain why fusion was necessary as opposed to decompressive surgery and records do not substantiate why fusion would be preferred over decompression. The appeal request was reviewed by Dr. on 10/17/12. Dr. non-certified the appeal request. Dr. reports that a peer to peer was conducted

with Dr., DC. He reports that Dr. indicated 3mm of retrolisthesis of L4 and L5, but there were no imaging studies to corroborate this. Dr. finds that as there are no flexion extension views and no evidence of segmental and instability the request cannot be certified.

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

This patient has a history of low back pain with radiation to the left lower extremity. He has received conservative management consisting of oral medications, physical therapy, and lumbar epidural steroid injection. The claimant has continued reports of low back pain with radiation into the left lower extremity. The claimant's electrodiagnostic studies note the presence of bilateral L5 and S1 radiculopathies. Imaging studies provided show small disc protrusions with evidence of degenerative changes that have resulted in evidence of neural foraminal stenosis at the L5-S1 level as well as a left lateralizing disc protrusion at the L5 level. The findings at L4-5 are minimal at best. The record includes lumbar flexion extension radiographs, which show no evidence of instability at either requested level. The claimant is not a candidate for a fusion procedure in the absence of instability and potentially would be a candidate for simple decompression. Therefore, based on submitted clinical information, the reviewer finds medical necessity is not established for the requested Inpatient Anterior Lumbar Interbody Fusion at L4-5 and L5-S1, Posterior Lumbar Decompression With Appeal: Posterolateral Fusion and Pedicle Screw Instrumentation at L4-5 and L5-S1 with a 2 Day Inpatient Stay.

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 KNOWLEDGBASE

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)