Applied Resolutions LLC

An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (214) 329-9005
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Nov/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L5/S1 Transforaminal Lumbar Interbody Fusion

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:

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

[X] 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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
handwritten medical records dated 03/31/12-04/23/12
Office visit notes dated 05/21/12-09/10/12
Emergency department records dated 06/22/12
Utilization review determination dated 09/14/12
Psychological evaluation dated 10/02/12
Radiographic report lumbar spine 4 views dated 10/03/12
Utilization review determination dated 10/12/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male whose date of injury is xx/xx/xx. The records indicate he was lifting when he experienced low back pain and pain radiating down the left lower extremity. The claimant initially was treated conservatively with physical therapy, medications, and injections, but remained symptomatic. MRI of the lumbar spine from 04/20/12 was noted to show normal bony alignment and normal lordotic curvature. There was advanced degenerative disc disease at L5-S1 with significant loss of disc height and bilateral foraminal stenosis from decreased pedicle to pedicle distance. There was also moderately severe stenosis. Mild to moderate degenerative disc disease with mild central stenosis was noted at L4-5. After failing conservative management, the claimant was recommended to undergo surgical intervention with L5-S1 TLIF.

A request for L5-S1 lumbar interbody fusion was determined as not medically necessary on 09/14/12. The reviewer noted that regarding L5-S1 fusion, ODG states that until further research is conducted, there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains understudied. Peer-to-peer discussion was completed with the requesting provider who stated he felt the fusion with interbody graft and instrumentation was predicated on advanced degree of degenerative disc space loss at L5-S1 which might not achieve decompression of the exiting S1 nerve root if discectomy and laminectomy alone were performed. Reviewer noted that ODGs do not cite medical necessity for fusion added to decompressive laminectomy in this setting. There is no imaging evidence of segmental instability. It was also noted that psychosocial clearance was not obtained.

A psychological evaluation was completed on 09/28/12 and determination for surgery was recommended. X-rays of the lumbar spine including flexion and extension views were obtained on 10/03/12. These radiographs reported no acute abnormalities. There was slight loss of height of the L1 vertebral body anteriorly. There were findings suggestive of a developmental abnormality rather than secondary fracture.

A reconsideration request for L5-S1 transforaminal lumbar interbody fusion was denied on 10/12/12. The reviewer noted that the claimant was reported to have failed conservative management consisting of oral medications, physical therapy, and injections. The previous request was denied due to the lack of pre-operative psychiatric evaluation, and lack of flexion and extension films. The submitted psychiatric evaluation does not provide supporting data to include BDI and BAI scores and does not provide a determination regarding suitability for surgery. The submitted lumbar flexion and extension views indicate no evidence of instability at the L5-S1 level. It was further noted that the claimant is a smoker with no documented plan regarding smoking cessation. It was determined that the claimant does not meet ODG criteria for the requested procedure based on the submitted clinical data.

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

Based on the clinical information provided, the request for L5-S1 transforaminal lumbar interbody fusion is not supported as medically necessary. The claimant sustained a lifting injury to the low back on xx/xx/xx. He complained of low back pain radiating down the left lower extremity. Records indicate that the claimant was treated conservatively with medications, physical therapy, and epidural steroid injections without significant improvement. MRI of the lumbar spine revealed degenerative disc disease at L5-S1 with a broad-based moderate central disc protrusion with central angular tear resulting in mild to moderate spinal stenosis. Electrodiagnostic studies revealed left L5 radiculopathy. X-rays including flexion/extension views on 10/03/12 revealed no acute abnormalities with no subluxation comparing flexion and extension views. There was slight loss of height of the L1 vertebral body anteriorly. The claimant had subjective complaints of worsening low back pain with shooting pain down the left leg, but no detailed physical examination report was submitted for review with assessment of motor, sensory, and reflex function. It does appear that the claimant was cleared for surgery from a psychological perspective; however, noting the absence of motion segment instability of the lumbar spine with no clinical examination findings indicative of neurologic deficit/radiculopathy, the proposed L5-S1 TLIF is not indicated as medically necessary. Moreover, the records indicate that the claimant is a smoker, which is a relative contraindication to lumbar fusion surgery.

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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)