# P-IRO Inc.

**An Independent Review Organization**
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/30/2012

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
360 Fusion @ L3/S1, Additional Level, Bilateral Laminectomy @ L5/S1, Spine Fusion Extra Segment, Insert Spine Fixation Device, Insert Spine Fixation Device, Removal of Spinal Lamina, Removal of Spinal Lamina Add-On, Spinal Bone Allograft, Bone Marrow Aspiration, Application of Intervertebral Prosthetic Device, Inpatient Hospital Stay 2-3 days

**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
Request for IRO
Utilization review determination 06/11/12
Utilization review determination 06/29/12
Work hardening progress reports
Clinical records Dr.
Clinical records Dr. 06/10/11-08/14/12
MRI lumbar spine 08/05/10
Radiographic report lumbar spine flexion extension views 10/07/11
CT myelogram lumbar spine 04/16/12
Pre-surgical psychological screening 06/01/12
Clinical notes Dr.
Clinical records DC
Operative report 08/27/08
Clinical records Dr.
Radiographic report lumbar spine five views 09/09/09
CT myelogram lumbar spine 04/17/09
MRI lumbar spine 02/23/09
Lumbar flexion extension radiographs 02/07/08
CT myelogram lumbar spine 01/15/08

MRI lumbar spine 07/26/07
MRI lumbar spine 11/10/06

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The claimant's a male who's reported to have sustained an injury to his low back as a result of lifting on xx/xx/xx. The records indicate that the claimant apparently failed conservative management and ultimately underwent lumbar surgery times two at L5-S1.

On 06/10/11 the claimant came under the care of Dr. He's reported to be unable to walk without a cane he reports his daily pain level to be at graded 6/10 he reports radiation with numbness and tingling into the bilateral lower extremities previous non-operative treatments have included steroid injections oral medications and physical therapy. Current medication on this date is gabapentin 600mg. On physical examination he's noted to be 69 inches tall and weighs 245 pounds. He is noted to have normal lumbar range of motion, right anterior tibialis is graded as 4/5, EHL 2/5, gastrocsoleus is 4/5. Sensation is decreased in the L4, L5 and S1 distributions. Achilles reflex is 1+ on the right. Straight leg raise is reported to be positive in the left lower extremity, anterior tibialis is graded as 3/5, EHL 2/5 and gastrocsoleus 4/5. Reflexes are 1+ at the Achilles. Straight leg raise is positive. Radiographs dated 11/07/07 indicate no evidence of instability and decreased disc space at L4 through S1. MRI of the lumbar spine dated 02/23/09 notes a large recurrent HNP at L3-4 of 6mm and a 7mm bulge at L5-S1 MRI dated 07/26/07 is reported to indicate findings of large HNPs at L3-4 and on the left side at L5-S1 the claimant is recommended to undergo CT myelogram of the lumbar spine. Records indicate that the claimant was recommended to undergo decompression with bilateral laminectomies at L3 through S1. The record includes lumbar flexion extension radiographs dated 10/07/11. This study notes disc space narrowing at L4-5 and L5-S1 with no evidence of instability. The claimant was subsequently recommended to undergo lumbar discography and he was offered a laminectomy for his radicular symptoms.

Records indicate that the claimant's pain management was conducted by Dr. He is reported to have undergone additional lumbar epidural steroid injections which resulted in no improvement.

On 04/16/12, the claimant underwent a CT myelogram of the lumbar spine. This study notes intervertebral disc space narrowing worse at L4-5 and L5-S1. There is clumping of the nerve roots at the L3-4 vertebral body as well as inferiorly at L4-5 consistent with arachnoiditis. There are prior laminotomy/laminectomies demonstrated from L3-4 through L5-S1. At L3-4 there's a residual 2mm posterior bulging of the disc extending into the inferior aspect of the foramen. At L4-5 there's a 2mm disc bulge demonstrated. There is a component of facet/flavum hypertrophy. At L5-S1 there are spondylitic changes. Vacuum disc phenomenon is demonstrated. There is a 2mm disc bulge extending into the inferior aspect of the foramen. There is a component of facet hypertrophy which results in moderate bilateral foraminal stenosis.

When seen in follow up on 05/11/12, it is recommended that the claimant undergo anterior and posterior fusion from L3 to S1 with bilateral L5-S1 laminectomy. On 06/01/12, the claimant was referred for pre-operative psychiatric evaluation the claimant was subsequently opined to be cleared for surgery

The record contains a letter from Dr. dated 08/14/12. Dr. reports that fusion is being recommended due to spondylitic changes at the specific levels. He reports to ignore fusing these elements would leave the patient with disabling back pain and that a laminectomy alone would not address this. Physical examination is grossly unchanged he is again recommended to undergo surgical intervention.

The initial review was performed by Dr. on 06/11/12. Dr. non-certified the request. A peer to peer was performed he notes that the patient's complaints are consistent with arachnoiditis and that there is no objective need to establish the necessity of the surgery proposed. He notes that this is the same presentation that was decided at an IRO with a similar conclusion

in 12/10

The appeal request was reviewed by Dr. on 06/29/12. Dr. opines that the claimant is suffering from arachnoiditis and that he will not benefit from a proposed fusion. He notes that the initial level determination was a similar conclusion per the independent review organization in 12/10. A peer to peer discussion was performed with Dr. DC. Dr. does not agree that the claimant suffers from radiculopathy therefore he does not agree with the need for destabilizing foraminotomies and a fusion.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**
The request for 360 degree fusion at L3 through S1, bilateral lumbar laminectomy at L5-S1 is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant has a history of multiple surgeries to the low back secondary to a work related lifting incident. The claimant has failed conservative management on at least two occasions resulting in surgical interventions. The most recent imaging studies indicate the presence of arachnoiditis at L3-4 and L4-5. This in all probability is the primary pain generator. And that appropriate treatment for this condition would be the continuation of oral medications and consideration of either an intrathecal pump or IDDS. Radiographs as presented show no evidence of instability therefore based on the totality of the clinical information the claimant would not be a candidate for a fusion procedure.

**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)**