

IRO Express 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:

Anterior Lumbar Interbody Fusion L4/5 L5/S1 Post Lumbar Decompression; and
Posterolateral Fusion Pedicle Screw Instrumentation L4/5 L5/S1

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

Board Certified Neurosurgeon

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

Procedure note dated 09/29/10

Electrodiagnostic studies 11/04/11

MRI lumbar spine 12/15/11

Radiographs lumbar spine 01/24/12

Psychological evaluation 01/27/12

Procedure note dated 04/13/12

Radiographs lumbar spine 06/18/12

Physical therapy notes 07/13/10-09/26/11

Clinic notes 05/03/11-06/08/12

Operative report 05/03/11

Letter to IRO 08/21/12

Prior reviews dated 06/27/12 and 07/30/12

Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who has been followed for complaints of low back pain radiating to lower extremities. The patient is status post lumbar laminectomy from L4-S1 on xx/xx/xx. Postoperative electrodiagnostic studies completed on 11/04/11 revealed continuing S1 radiculopathy bilaterally. MRI of the lumbar spine completed on 12/15/11 revealed moderate disc desiccation at L4-5 and L5-S1. A circumferential disc bulge was noted at L4-5 mildly impressing on thecal sac. Moderate foraminal narrowing was noted bilaterally. Modic type II

degenerative changes in endplates at L4-5 were noted. At L5-S1 there was a central disc protrusion moderately impressing on the thecal sac. Marked foraminal stenosis was noted bilaterally at L5-S1 with Modic type II degenerative changes at endplates. The patient was evaluated on 01/03/12 for complaints of recurrent lower extremity pain right worse than left. Physical examination at this visit revealed loss of range of motion in lumbar spine on forward flexion. Mild weakness was noted in right tibialis anterior and extensor hallucis longus. Reflexes were slightly reduced at right ankle. The patient demonstrated antalgic gait and performed with difficulty on toe and heel walking. Straight leg raise was positive bilaterally at 45 degrees and there was hypoesthesia to pinprick in right L5 and S1 distributions. Radiographs of lumbar spine completed on 01/24/12 revealed no interspace subluxation. The patient underwent psychological evaluation on 01/27/12 which did not reveal any psychological contraindications for lumbar fusion. BDI score was 16 and BAI was 13 indicating mild depression and anxiety. No validity testing was performed. Follow-up on 03/20/12 stated the patient continued to have significant numbness and right lower extremity pain that was controlled with use of Hydrocodone or Neurontin. Physical examination revealed loss of range of motion of the lumbar spine with sensory deficits in a L5-S1 dermatome to the right. Mild weakness in the right lower extremity was present and positive straight leg raise at 65 degrees was noted to the right. The patient was recommended for an epidural steroid injection at this visit which was completed on 04/13/12. Follow up on 04/24/12 stated the patient continued to have burning sensations in the right lower extremity that was not improved with epidural steroid injections. Follow up on 06/08/12 reported no changes in the patient's continuing low back pain or right lower extremity pain. Physical examination was unchanged with exception of straight leg raise which was now positive to the right at 20 degrees. Radiographs of the lumbar spine with flexion and extension views revealed no evidence of subluxation. A letter dated 08/21/12 indicated that due to the nature of the patient's facet arthrosis on MRI studies, wide decompression was recommended which would reasonably produce instability that would require fusion. The request for lumbar fusion at L4-5 and L5-S1 was denied by utilization review on 06/27/12 as there was no clear evidence regarding lumbar radiculopathy and no indications for anterior posterior fusion per Official Disability Guidelines. The request for surgery was again denied by utilization review on 07/30/12 as there was no evidence of radiculopathy and a fusion surgery was not likely to reduce the patient's subjective complaints. The patient was also noted to smoke and is morbidly obese

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

The request for anterior lumbar interbody fusion at L4-5 and L5-S1 with posterolateral pedicle screw and instrumentation L4-5 L5-S1 with lumbar decompression is not recommended as medically necessary based on the clinical documentation provided for review. The clinical documentation does establish the presence of L5-S1 radiculopathy based on electrodiagnostic studies and physical examination. The December 2011 MRI study did reveal foraminal narrowing secondary to disc protrusions and there was bilateral facet arthrosis noted; however, the MRI study did not identify any severe facet overgrowth at L4-5 or L5-S1 that would support the use of extensive facetectomies that would potentially destabilize the lumbar segments. No significant lateral recess stenosis was identified that would support a wide decompression removing the facets and posterior elements thus requiring lumbar fusion. It is also unclear why the patient would be recommended for an anterior lumbar interbody fusion when radiograph studies of the lumbar spine show intact disc spaces with no significant disc space collapse. Also the patient is noted to have been a smoker since January of 2012 and it is unclear if the patient has been counseled on smoking cessation or successfully quit smoking. No laboratory studies clearing the patient of any nicotine use were provided for review. As the clinical documentation provided for review does not establish the need for lumbar fusion as indicated in the clinical documentation medical necessity would not be established and 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)