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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/13/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 360 fusion L5-S1 with bilateral laminectomy, IN-PT stay 3 days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic 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. It is this reviewer's opinion that medical necessity is not established for the requested 360 fusion L5-S1 with bilateral laminectomy, IN-PT stay 3 days at this time and the prior denials are upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy treatment reports dated 07/24/12 – 07/18/13
Treatment plans for physical therapy dated 08/09/12 – 11/26/12
Personal injury diagnosis sheet dated 07/18/12
Functional capacity evaluations dated 08/01/12 – 10/10/12
Emergency room report dated 07/18/12
Clinical notes dated 07/30/12 – 05/20/13
Procedure reports dated 12/12/12 – 05/03/13
Behavioral assessments dated 12/17/12 & 04/12/13
Electrodiagnostic study dated 05/12/12
MRI of the lumbar spine dated 08/31/12
CT myelogram of the lumbar spine dated 02/11/13
Clinical reports dated 09/25/12 – 06/11/13
Summary letter to IRO dated 07/26/13
Prior reviews dated 07/05/13 & 07/18/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he fell. The patient described complaints of low back pain as well as pain in the left side. The patient is noted to have undergone extensive physical therapy from July of 2012 through July of 2013. Electrodiagnostic studies completed on 08/15/12 revealed no evidence of lumbar radiculopathy. MRI studies of the lumbar spine completed on 08/31/12 showed a disc protrusion at L5-S1 measuring 2-3mm beyond the vertebral end plates effacing the thecal sac without displacement of the descending S1 nerve roots. Mild anterior spondylosis and slight disc desiccation was noted. There was a focal signal within the L5 vertebral body consistent with an hemangioma. CT myelogram studies of the lumbar spine

completed on 02/11/13 showed a disc protrusion again at L5-S1 measuring 6mm and mildly impinging the thecal sac and right S1 nerve root within the lateral recess. The patient did undergo multiple injections to include facet medial branch blocks at L3-4 in October of 2012 followed by lumbar rhizotomy at L3-4 in November of 2012. The patient also had epidural steroid injections completed in May of 2013 at L5-S1. The patient reported no benefits from previous epidural steroid injections as well as the radiofrequency ablation procedures. The patient continued to report bilateral leg weakness.

There was a presurgical psychological evaluation on 04/12/13. The patient had minimal scores for depression and scores for mild anxiety; however, the patient's fear avoidance scores were at maximum for both physical activity and work. MMPI2 values were reported as valid. The evaluator felt that there were minimal psychological contraindications for surgery. Clinical report on 06/11/13 stated that the patient continued to have complaints of left lower extremity pain as well as left foot and leg numbness. The patient's physical examination demonstrated weakness in the right gastrocnemius and decreased sensation in an S1 dermatome. Reflexes were 1+ and symmetric. There was also mild weakness and decreased sensation in the left lower extremity at the gastrocnemius and in an S1 dermatome respectively. The patient was recommended for an anterior posterior L5-S1 fusion at this visit. indicated in his summary letter to the IRO on 07/26/13 that due to the extensive facetectomies planned, this would create iatrogenic instability requiring a lumbar fusion.

The request for a 360 degree lumbar fusion with a 3 day inpatient stay was denied by utilization review on 07/05/13 as the patient's subjective complaints and physical examination findings were not consistent with MRI studies showing a contact of the right S1 nerve root. There was also no evidence of stenosis, spondylolisthesis, or motion to support lumbar fusion.

The request was again denied by utilization review on 07/18/13 as there was no indication to support structural instability that would require fusion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has reported ongoing complaints of low back pain as well as radiating pain into the left lower extremity. In this case, there is limited evidence to support lumbar radiculopathy as prior electrodiagnostic studies were negative for evidence of lumbar radiculopathy and MRI studies showed no clear evidence of displacement of the left S1 nerve roots. Further CT myelogram studies of the lumbar spine did show a disc protrusion at L5-S1; however, this contacted the right S1 nerve root within the lateral recess. There are insufficient findings for any left sided neurocompressive pathology that would reasonably be consistent with the patient's objective and subjective findings to the left lower extremity. Furthermore, the patient reported no benefits from injections and it is unclear whether the patient's pain generators have been established at this time to justify decompression followed by lumbar 360 degree fusion. As the clinical documentation submitted for review does not meet guideline recommendations for lumbar fusion, it is this reviewer's opinion that medical necessity is not established for the requested 360 fusion L5-S1 with bilateral laminectomy, IN-PT stay 3 days at this time 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)