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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 8/8/13

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of an inpatient excision recurrent disc herniation L1 left, excision HNP T12 right, posterior fusion T12-L2 with expedium allograft.

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

The reviewer is a Doctor of Osteopathy who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

### **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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an inpatient excision recurrent disc herniation L1 left, excision HNP T12 right, posterior fusion T12-L2 with expedium allograft.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: quick notes 7/15/13 to 7/19/13, PT daily notes from 7/1/13, notes 6/4/12 to 6/13/13, 3/12/13 thoracolumbar post myelogram CT report, 3/12/13 thoracolumbar myelogram report, 3/12/13 hematology and coagulation studies reports, 2/26/13 electrodiagnostic report, 2/5/13 lumbar MRI report, 12/7/12 operative report, 12/6/12 history and physical report, 11/26/12

patient requisition report, 6/12/12 to 11/26/12 notes, notes 9/11/12 to 2/26/13, 8/20/12 ESI note, and 6/14/12 RADAR report.

5/14/13 report, 4/24/12 lumbar and thoracic MRI reports, PT eval and notes 3/1/12 to 5/16/12, EMC progress medical exams and notes 2/28/12 to 10/8/12, 6/4/13 note, and 10/31/12 DD report.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This case involves a male who has a history of xx/xx/xx injury while stepping onto a curb when he fell backwards hitting his head, back, left elbow and left little finger. The patient subsequently failed conservative treatment and underwent lumbar laminotomy and discectomy L1 on the left in December of 2012. The patient did have a pre-existing history of L5/S1 fusion. Postoperatively the patient continued to complain of back pain with lower extremity pain. A post-operative MRI of the lumbar spine noted a moderate sized right posterior lateral disc protrusion at T12-L1, following mild deformity of the thecal sac, a mild/moderate right neural foraminal narrowing with no cord compression and postop surgical changes at L1-2 with left laminotomy and discectomy with moderate sized left posterior lateral disc protrusion. has continued to follow the patient for back and leg complaints with a subsequent recommendation to start PT that had not initially been instituted after surgery. With failure of the conservative treatment a CT myelogram was performed of the lumbar spine which noted asymmetric right canal narrowing and right foraminal narrowing at T12-L1 and L1-2 left paracentral to foraminal prominent disc osteophyte complex with prominent osteophyte impressing on the anterior lateral thecal sac with asymmetric left canal and left foraminal narrowing at least to a moderate degree. recommended T12-L1 and L1-2 fusion with excision of HNP T12 and excision recurrent HNP at L1 after a post CT myelogram.

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

The medical records provided for review did not document the evidence of a lesion that fits within the guidelines of the ODG for this procedure. 1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support

for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria include lumbar inter-segmental movement of more than 4.5 mm. (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. Due to the lack of fitting within the above guidelines, the requested procedure is found to not be medically necessary at this time.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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)