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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: anterior and posterior spinal fusion with instrumentation and decompression, L4-S1 CPT 72265, 73132, with 5 inpatient days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Neurosurgery

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 the opinion of this reviewer that medical necessity is not established for anterior and posterior spinal fusion with instrumentation and decompression, L4-S1 CPT 72265, 73132, with 5 inpatient days

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Medical peer review 02/22/13
Clinical record 03/14/11-08/08/11
MRI lumbar spine 03/14/11
Procedure notes 03/17/11
Clinical record 04/06/11-04/18/13
Procedure note 05/05/11
Clinical record 10/27/11 and 06/20/12
CT lumbar spine 05/11/12
Discogram report 11/05/12
Post-discogram CT 11/05/12
Radiographs lumbar spine 12/19/12
Psychosocial assessment 12/28/12
Clinical record 02/11/13
Electrodiagnostic studies 02/20/13
MRI lumbar spine 04/15/13
Prior reviews 03/13/13 and 03/28/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who initially sustained an injury on xx/xx/xx after she fell. Prior to the date of injury the patient was being followed for complaints of low back pain radiating to the lower extremities. Initial MRI studies from 03/14/11 demonstrated mild degenerative disc disease at multiple levels from L3 to S1 with no evidence of significant canal or neural foraminal stenosis from L2 to S1. The patient had epidural steroid injections and facet joint

injections in 2011 with no real response documented. The patient also had bilateral sacroiliac joint injections in 08/11 with no significant improvement. CT of the lumbar spine on 10/03/11 demonstrated disc bulging at L3-4 and L4-5 with no evidence of deformity or compression of the thecal sac. Lateral recesses were widely patent without compromise of the exiting nerve roots. The patient continued to receive facet joint injections and epidural steroid injections with minimal improvement. The patient underwent discography from L3 to S1 on 11/05/12. Per the discography report there was non-concordant pain at L4-5 and concordant pain at L5-S1. Post-discogram CT on 11/05/12 demonstrated annular bulging with contrast within the disc space extending to the annular surface consistent with a radial tear. At L5-S1 there was contrast from the annulus with minimal extension.

felt that the patient was a surgical candidate due to the discography results and was recommended for anterior lumbar interbody fusion at L4-5 and L5-S1 on 11/20/12. Flexion extension views of the lumbar spine on 12/19/12 were unremarkable. The patient underwent psychological evaluation on 12/28/12. BDI and BAI scores were in the mild range for depression and anxiety. No validity testing was performed. The patient was cleared for surgical intervention. reported on 01/17/13 that the patient had spondylolisthesis at L4-5 with motion that increased and reduced with flexion extension views. A second opinion was performed on 02/11/13. felt that the flexion extension views showed 1mm slippage at L4-5 with no motion at L5-S1. Physical examination demonstrated restricted range of motion in the lumbar spine on flexion extension. Reflexes were trace to absent at the ankles. Slight numbness was present in the proximal left lateral thigh. agreed with the recommendation for anterior lumbar interbody fusion at L4-5 and L5-S1. Electrodiagnostic studies on 02/20/13 reported evidence of multi lumbar radiculopathy from L2 to S1. The paraspinals were not tested on this study. There was a repeat MRI of the lumbar spine on 04/15/13 which identified disc bulging at L4-5. No significant disc bulging was present at L5-S1. There was no evidence of significant canal or neural foraminal stenosis at L4-5 or L5-S1. Follow up with on 04/18/13 reported continued loss of range of motion in the lumbar spine with pain. The patient was gain recommended for anterior lumbar interbody fusion at L4-5 and L5-S1. The request for anterior lumbar interbody fusion at L4-5 and L5-S1 with decompression with an inpatient date with five days inpatient stay was denied by utilization review on 03/13/13 as there was no evidence of motion segment instability and only minimal degenerative changes at L4-5. The patient had non-concordant pain on discogram studies. The request was again denied by utilization review on 03/28/13 as there was no correlating finding on physical examination with imaging studies and there was questionable result from discography to support lumbar fusion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: From the clinical records the patient has been followed for ongoing chronic low back pain. There is no evidence of neurological deficits or significant findings on imaging studies to support a diagnosis of lumbar radiculopathy that would reasonably require lumbar decompression. Moreover, the imaging studies failed to identify any significant motion segment instability severe spondylolisthesis or motion or completed disc space collapse at either L4-5 or L5-S1 that would warrant surgical intervention. Although the patient was cleared for surgery from a psychological perspective the testing did not include validity and the evaluation did not include validity testing which would support the conclusions made regarding the appropriateness for surgery. As the clinical documentation submitted for review does not meet guideline recommendations for the requested services it is the opinion of this reviewer that medical necessity is not established for anterior and posterior spinal fusion with instrumentation and decompression, L4-S1 CPT 72265, 73132, with 5 inpatient days 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)