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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-5-S1 revision lumbar spine surgery, hardware removal, exploration of fusion, L2-3-4, decompression of stenosis AISF, PISF EBI, inpatient length of stay 2 days

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

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)
[X] 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. It is this reviewer's opinion that the proposed L4-5-S1 revision lumbar spine surgery, hardware removal, exploration of fusion, L2-3-4, decompression of stenosis AISF, PISF EBI, inpatient length of stay 2 days would be medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx. The patient developed cauda equina syndrome and required emergent surgery to include lumbar decompression and fusion from L4 to S1. MRI studies of the lumbar spine from 04/08/08 identified postoperative changes from L4 to S1. At L3-4, there was normal height and disc hydration with no evidence of adjacent level disease. The patient was followed by pain management through 2013 when she was referred due to chronic low back and left lower extremity pain. The patient reported some benefit from prior radiofrequency ablation procedures; however this was temporary. The evaluation on 12/17/13 identified positive sacroiliac joint findings as well as hypoactive reflexes in the left lower extremity. There was paresthesia in a left L4 through S1 nerve root distribution with weakness at the left gastrocsoleus and tibialis anterior. The patient was prescribed Hydrocodone and Zanaflex at this visit and recommended for updated imaging. The patient did have a CT myelogram study of the lumbar spine completed on 01/06/14. Mild degenerative changes were apparent at L3-4 with more moderate degenerative changes at L2-3 with evidence of a large disc bulge or protrusion contributing to moderate/severe central canal stenosis.

Post-myelogram CT showed solid fusion from L4 to S1 with no evidence of canal or foraminal stenosis. At L2-3, there was an extruded left sided posterior lateral disc herniation abutting the left L3 nerve root and compressing the left L2 nerve root. There was substantial right foraminal stenosis as well at L2-3. At L3-4, there was mild loss of the disc height with a 3mm disc bulge compressing the bilateral L3 nerve roots mildly within the neuroforamina. felt that there was malplaced hardware. He recommended revision spinal surgery with a total

laminectomy and facetectomy from L2 to L4 with revision procedures at L4 to S1.

The requested surgical procedures were non-certified by utilization review on 01/28/14 as there was no documentation regarding diagnostic hardware blocks to confirm hardware as a pain generator. There was no evidence of instability.

The request was again denied by utilization review on 02/27/14 as there were no imaging findings for pseudoarthrosis from L4 to S1 to support exploration and revision of the fusion grafts at these levels.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for a multi-year history of chronic pain following an L4 through S1 lumbar fusion to address cauda equina performed in 2003. The patient reported increasing pain in the left lower extremity that had not improved with medications or radiofrequency ablation procedures. Updated imaging including CT myelogram studies of the lumbar spine did show severe canal stenosis at L2-3 secondary to a large disc herniation measuring 4-5mm with associated foraminal stenosis. There was also evidence of nerve root compression bilaterally at L3-4 due to disc bulging. In this case, there are clear indications for lumbar fusion from L2 to L4 due to the severe canal stenosis and foraminal encroachment at both L2-3 and L3-4. At this point in time, the patient would not reasonably improve with non-operative treatment. Given that surgery including anterior and posterior lumbar fusion from L2 to L4 is indicated as medically necessary, the patient would require removal of the previous hardware from L4 to S1 followed by new hardware placed from L2 to S1. During these procedures, removal of the hardware would be followed by exploration of the previous lumbar fusion graft for any complications. Given the multi-level fusion request, there is a substantially higher risk for postoperative nonunion. Therefore, this would reasonably require an electrical bone growth stimulator. The patient would also require a 2 day inpatient stay for postoperative monitoring for any possible complications. As such, it is this reviewer's opinion that the proposed L4-5-S1 revision lumbar spine surgery, hardware removal, exploration of fusion, L2-3-4, decompression of stenosis AISF, PISF EBI, inpatient length of stay 2 days would be medically necessary. As such, the prior denials are overturned.

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)