

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/06/2014

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** L1-2-3 revision laminectomy, discectomy, fusion PISF, L3-4 repair pseudoarthrosis, removal PCS, electrodes, 2 days inpatient

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery and Fellowship Trained Spine Surgery

**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 the proposed p L1-2-3 revision laminectomy, discectomy, fusion PISF, L3-4 repair pseudoarthrosis, removal PCS, electrodes, 2 days inpatient is not medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who sustained an injury on xx/xx/xx. The patient is noted to have undergone previous surgical intervention to include revision lumbar fusion from L3 through S1 with placement of a bone growth stimulator unit on 12/19/11. The patient's bone growth stimulator generator was removed on 07/09/12. Radiographs of the lumbar spine from 12/13/12 noted a grade 1 anterolisthesis of L5 on S1 with a spinal cord stimulator device partially visualized. Post-surgical changes from L2 to L5 were notable. No instability or complication of the hardware was identified. Following surgery, the patient was recommended to attend a work hardening program. There was a notation regarding a CT study showing adjacent level disease at L1-2 and L2-3; however, there was no documentation regarding any updated CT scans for the lumbar spine. I did recommend discography at L1-2 and L2-3. The patient was evaluated on 06/24/14. Per the report, the patient did not have discography performed at L1-2 and L2-3.

Recommendations were for removal of the spinal cord stimulator at this evaluation followed by instrumented fusion from L1 to L3. Hardware removal was recommended at L3 followed by further instrumentation with discectomy and interbody fusion at L2-3. No specific physical examination findings were reported at this evaluation.

The requested L1, L2, and L3 revision laminectomy, discectomy, and fusion, posterolateral fusion with implantable bone growth stimulator, L3-4 repair of pseudoarthrosis, removal of PCS and electrodes with a 2 day inpatient stay was denied by utilization review on 07/07/14 as there was clarification needed regarding the requested procedures and platelet rich plasma injections were not supported in the clinical literature.

The request was again denied by utilization review on 07/15/14 as indicated on 04/24/14 the patient was not a candidate for additional surgery and there was no indication of a prior fusion from L1 to L3 that would have required revision procedures.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for chronic complaints of low back pain radiating to the lower extremity and has undergone multiple surgical procedures to include placement of a spinal cord stimulator. is noted in concluding that there was adjacent level segment disc disease at L1-2 and L2-3; however, no imaging studies beyond December of 2012 were provided for review confirming the presence of severe adjacent level disc disease at either L1-2 or L2-3 that would require surgical intervention. There was no further evidence from imaging regarding pseudoarthrosis at L3-4 which would have also required surgical intervention. Given the absence of any imaging studies to establish pathology that would be consistent with the surgical requests made it is this reviewer's opinion that the proposed p L1-2-3 revision laminectomy, discectomy, fusion PISF, L3-4 repair pseudoarthrosis, removal PCS, electrodes, 2 days inpatient is not medically necessary per guidelines. Therefore, 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)