

Notice of Independent Review Decision

June 18, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal IP lumbar fusion and instrumentation at L4-S1 22612, 22614x2, 22840
20936

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

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 of the health care services in dispute.

Upon independent review, the physician finds that the previous adverse determination should be ~ Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received:

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured xx/xx/xx. The patient subsequently underwent a decompressive laminectomy, foraminotomy, at L4-5 and L5-S1 10/26/12. Postoperatively, the patient was provided medication, physical therapy, and a home exercise program. Subsequently, on 10/28/13, the patient reported increasing back pain and radiating left leg pain. X-rays noted an L5-S1

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retrolisthesis that did reduce in flexion. A CT/myelogram 02/24/13 noted moderate spondylosis of L5-S1 with minimal retrolisthesis, at L4-5, a borderline congenital stenosis of the central canal without recurrent disk herniation and no instability identified. The L5-S1 level was notable for mild right, moderate left, foraminal stenosis with contact of the L5 nerve root. On myelogram, the left L5 nerve root had underfilling. The 02/24/14 electrodiagnostic study noted left S1 and right L5 nerve root irritation.

The 01/29/14 evaluation recommended a CT scan with myelogram and electrodiagnostic study after diagnosing a post-laminectomy syndrome, lumbar spine, lumbar intervertebral disk without myelopathy, degenerative lumbosacral intervertebral disk, lumbosacral spondylosis, spinal stenosis, lumbar, lumbosacral neuritis/radiculitis, low back pain. The physical examination noted a forward-flexed posture with painful straight leg raising on the left. There was weakness with heel walking on the right. Lumbar range of motion noted decreased right and left rotation, decreased right and left lateral flexion, extension neutral with low back pain, and flexion to proximal tibias with low back pain. An antalgic gait was identified. The patient was stooped in the sagittal plane. Neurologically, there was weakness to the left EHL 4+/5, left TA 4+/5, and left quad 4/5 versus G/W secondary to pain. Sensation was intact. In the lower extremities, with the exception of the left anterior proximal thigh and paradistal thigh, plantar aspect of the left lateral foot. DTRs were 2+ except left ankle at 1+.

It is notable that there was a psychosocial assessment that recommended follow-up psychological treatment prior to considering surgery.

The lumbar spine x-rays with flexion/extension 4/08/14 noted moderate degenerative changes in the lumbar spine. on 04/10/14 recommended the surgical procedure and noted the psych evaluation confirmed he was psychologically prepared and appropriate for surgery.

The previous denials both documented lack of findings at L4-5 supporting surgical intervention at that level, and noted the psychological assessment recommending six sessions prior to surgery, which would not support the patient's being psychologically prepared for surgery.

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

The L4-5 level does not have findings that would support a lumbar fusion within ODG recommendations, as the findings did not document an instability at L4-5. While the L5-S1 level does have findings supportive of the need for surgery, there has not been documentation of exhaustion of an appropriate course of conservative treatment, and with the psychological evaluation provided for review, the patient is not psychologically ready for surgical treatment. Therefore, the

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requested L4-5 and L5-S1 fusion with instrumentation is not medically necessary within *ODG* recommendations.

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)