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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/16/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: L4-S1 posterior lumbar interbody fusion

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 this reviewer's opinion that medical necessity for L4-S1 posterior lumbar interbody fusion in this case is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of low back pain radiating to the left buttocks. The patient was initially treated with anti-inflammatories, muscle relaxers, and analgesics for pain. The patient did receive epidural steroid injections at L4-5 and at L5-S1 on 12/06/07. It is noted the patient was able to return to full duty by February of 2008. The patient had a return of symptoms in March of 2014 to include limited lumbar range of motion with paraspinal spasms. The patient was placed back on medications to include anti-inflammatories, muscle relaxers, and narcotic analgesics. The patient did complete physical therapy in April of 2014. MRI studies from November of 2007 did note disc protrusions at L4-5 and at L5-S1 compressing the exiting nerve roots at L4-5. There was stenosis at L5-S1. An updated MRI study of the lumbar spine from 04/22/14 noted disc bulging at both L4-5 and at L5-S1 with annular tearing and facet joint degeneration contributing to mild canal stenosis with mild to moderate right foraminal stenosis and moderate left foraminal stenosis. At L5-S1, there was a mild amount of spinal canal stenosis as well as mild right and moderate left foraminal stenosis. Radiographs of the lumbar spine with flexion and extension views dated 06/24/14 noted vacuum disc phenomena at L5-S1 with mild disc space narrowing. There was mild spondylosis at T12-L1. No subluxation on flexion or extension views was noted. There was fair range of motion without evidence of spondylolysis or spondylolisthesis. The patient initially denied any weakness or paresthesia below the knee when he was evaluated. Despite physical therapy, the patient did continue to report low back pain. The patient's physical examination noted restricted lumbar range of motion with tenderness in the paraspinal musculature. Straight leg raise was reported as positive to the right; however, heel and toe walking was normal. Sensation was intact with the exception of the right L4 and L5 dermatomes. The patient was started on a Medrol dose pack at this evaluation. The patient was seen on 05/30/14. The patient reported continuing low back pain radiating to the lower extremities in an S1 distribution. This was worse to the right side than to the left. These symptoms continued despite physical therapy and medications. On physical

examination, there was tenderness to palpation in the lumbar midline as well as the paraspinal musculature. The patient was felt to have axial low back pain with some amount of instability from L4 through S1. There were recommendations for an L4 through S1 posterior lumbar interbody fusion.

The requested L4-5 and L5-S1 posterior lumbar interbody fusion with a 2 day inpatient stay was denied by utilization review on 07/18/14 as there were no focal objective sensory or motor deficits with the absence of frank disc herniations on the 04/22/14 MRI. There was no evidence of spondylolisthesis or motion segment instability and no further diagnostic evidence of radiculopathy such as electrodiagnostic studies.

The request was again denied by utilization review on 08/25/14 as there was a lack of clearly defined radiculopathy or evidence of focal disc protrusions at L4-5 or L5-S1.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of chronic low back pain due to a re-exacerbation of symptoms from an older date of injury. Based on the patient's most recent MRI findings, there is 2 level degenerative disc disease at L4-5 and L5-S1 contributing to some extent of foraminal stenosis without clear nerve root impingement. Radiographs of the lumbar spine did note vacuum disc phenomena at L5-S1 without evidence of instability or any spondylolisthesis. Based on the most recent evaluation he felt that the patient did have instability and spondylolisthesis at L4-5 and L5-S1 that would warrant surgical intervention. The patient was felt to have an axial low back pain component. The patient's physical examination findings and symptoms are inconsistent for lumbar radiculopathy as there are several mentions in the clinical reports that the patient denied any lower extremity symptoms below the knees. Given the patient's primarily axial complaints, guidelines would recommend preoperative psychological evaluations to rule out any confounding issues that could possibly impact postoperative recovery. This is not documented in the clinical records provided for review. Given the absence of any clear evidence of instability or focal disc herniations impinging the nerve roots and as no further diagnostic evidence for lumbar radiculopathy such as EMG was available for review, it is this reviewer's opinion that medical necessity for L4-S1 posterior lumbar interbody fusion in this case is not established based on guideline recommendations for the proposed procedures. Therefore, the prior denials are upheld for the surgical request and the inpatient stay.

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)