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An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: May/12/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Anterior lumbar interbody fusion with posterior lumbar decompression at L4-L5, L4-S1 with intraoperative monitoring and inpatient hospitalization: 2 days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Neurological 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 the opinion of this reviewer that the request for anterior lumbar interbody fusion with posterior lumbar decompression at L4-L5, L4-S1 with intraoperative monitoring is medically necessary. As the surgical request is medically necessary, inpatient hospitalization: 2 days is also medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female. On XX/XX/XX, a lumbar CT myelogram was performed revealing mild spondylotic disc narrowing and gas vacuum at L3-4. There was mild to moderate spondylotic disc narrowing and gas vacuum at L4-5. Annular bulging was seen without obvious nerve root impingement. There was bilateral facet joint degeneration noted. There was widening of the left facet joint at L4-5 suggestive of a possible joint effusion. There was mild to moderate spondylotic disc narrowing, gas vacuum, and annular bulging at L5-S1, creating foraminal stenosis impinging upon the exiting L5 nerve roots. There was mild facet joint degeneration at that level. On XX/XX/XX, the patient was seen in clinic. It was noted the patient had been seen for epidural steroid injection x 1 without significant benefit. The pain was rated at 3/10. Pain was to the low back radiating into the left lower extremity along the lateral thigh and calf and into the dorsum and lateral aspect of the left ankle. There was associated numbness and tingling in a similar distribution. On exam, there was 4/5 strength to the tibialis anterior, extensor hallucis longus, and gastroc muscles on the left, otherwise strength was preserved.

Deep tendon reflexes were 1+ at the ankle jerk on the left, otherwise 2+ throughout and symmetrical. Straight leg raise was positive on the left. There was a hypoesthetic region over the L5 and S1 distribution on the left. Due to the failure of conservative measures, and positive imaging findings, an anterior lumbar interbody fusion at L4-5 and L5-S1, with posterior lumbar decompression to include bilateral facetectomies at both levels, predisposing the patient to iatrogenic instability, with a posterolateral fusion and pedicle screw instrumentation at L4-5 and L5-S1 was recommended. On XX/XX/XX, a psychological report indicated that the patient presented with some depressive symptoms but not to the degree that would preclude from a surgical intervention. It was noted the patient was an appropriate surgical candidate as far as psychological and psychosocial issues were concerned.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review determination letter was submitted indicating the requested procedure involving an anterior lumbar interbody fusion with posterior lumbar decompression at L4-5 and L4-1 was non-certified. It was noted, it remained unclear when the patient needed a lumbar fusion as opposed to decompression alone.

On XX/XX/XX, a utilization review report non-certified the request for an anterior lumbar interbody fusion with posterior lumbar decompression at both L4-5 and L4-1, and it was noted the medical records did not specifically discuss the response to prior non-operative treatment was recommended by the guidelines. There was a history of psychological conditions and the medical records did not include a pre-operative psychological evaluation ruling out any significant issues that could possibly impact post-operative recovery. Therefore, the request was non-certified.

The submitted records now include a psychosocial evaluation, clearing the patient for surgery. The provider has stated that the decompression would create iatrogenic instability, necessitating the posterior fusion. The provider stated that the patient has failed conservative measures including physical therapy, which did not make her better, and an epidural steroid injection which did not provide long lasting benefit.

The guidelines state that this procedure may be considered reasonable for those patients who have failed lesser measures, who have been cleared from a psychological perspective, and have continued to have functional deficits. The patient has functional deficits, has been cleared from a psychosocial evaluation, and has failed conservative measures.

It is the opinion of this reviewer that the request for anterior lumbar interbody fusion with posterior lumbar decompression at L4-L5, L4-S1 with intraoperative monitoring is medically necessary and the prior denials are overturned. As the surgical request is medically necessary, inpatient hospitalization: 2 days is also medically necessary.

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)