

True Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 01/18/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Inpatient anterior lumbar interbody fusion, posterior percutaneous fusion at the L5-S1 levels with 2 days hospital length of stay

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)

Patient Clinical History (Summary)

The patient is a male who was injured on XX/XX/XX when he was involved in a motor vehicle accident. The patient had been followed for complaints of low back pain radiating to the lower extremities primarily to the left side involving the hamstring and calf. Prior treatment had included nine physical therapy sessions or more as well as two separate epidural steroid injections without relief. MRI studies of the lumbar spine from XX/XX/XX noted a convex thoracolumbar scoliosis from T11 to L5. The L5-S1 level was a vestigial level with no evidence of central or neural foraminal narrowing. At L4-5 there was a 5mm anterolisthesis with uncovering of the disc and evidence of moderate neural foraminal narrowing. Moderate to severe central stenosis was evident at L2-3 and at L3-4. Medications for this patient included anti-inflammatories, muscle relaxers, antidepressants, and anticonvulsants. The patient was being followed by XX who recommended epidural steroid injections. The XX/XX/XX report noted continuing back pain and left leg pain. The patient's physical examination noted painful range of motion in the cervical spine. There were positive Hoffman signs noted as well as positive Spurling signs. There was limited range of motion in lumbar spine up here straight leg raise was reported as positive to the left at 75 degrees. Motor strength and reflexes were intact in the lower extremities. There was no sensory loss evident. The patient had a psychological evaluation completed XX/XX/XX which found no contraindication for surgical procedures. The proposed anterior and posterior lumbar spine fusion was denied by utilization review on XX/XX/XX as there was no indication of instability and degenerative changes at L3-4 and L4-5 to the extent that fusion at L5-S1 would be contraindicated. The XX/XX/XX utilization review noted limited objective findings for deficits and lack of imaging to support this stroke the surgical request.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical records submitted, the proposed anterior lumbar interbody fusion as well as posterior fusion at L5-S1 would not meet guideline recommendations in regards to medical necessity. The

imaging studies noted a vestigial disc at L5-S1 which is most consistent with a transitional level. At L4-5 there was an anterolisthesis present with uncovering of the disc contributing to some neural foraminal narrowing. MRI studies noted extensive central stenosis at L2-3 and L3-4 which could reasonably be pain generators in this case. The patient's physical examination findings also noted objective evidence for cervical myelopathy. It is unclear why lumbar spine fusion procedures are being considered in the clinical setting of cervical myelopathy which is a more concerning condition with potential for permanent neurological damage. The patient has no trauma to the lumbar spine or any evidence of motion segment instability. The records did not include any recent evaluation of this patient. Given the lack of updated clinical evaluations for the patient as well as other more pertinent physical examination findings for cervical myelopathy and potential pain generators above the L5-S1 level, it is this reviewer's opinion that medical necessity for the request has not been established and the prior denials remain upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)