

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four-level spine surgery with fusion from L4 to S1 and decompression disc excision at L2 and L3/L4 with implantation of bone growth stimulator, examination under anesthesia, revision lumbar spine syndrome, discectomy, decompression arthrodesis post instrumentation, implantation of bone growth stimulator, and two-day hospital stay.

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

M.D., board certified Orthopedic Surgeon and board certified Spine Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Adverse Determination Letters dated 11/6/07 and 11/21/07
2. ODG Guidelines and Treatment Guidelines
3. M.D., 08/21/07, 09/11/07, and 11/07/07
4. MRI scan of lumbar spine with contrast dated 09/07/07
5. Dr. 02/22/06, 4/25/06
6. D.C., 08/03/07, 04/13/07

7. D.C., 01/05/06
8. records, 11/20/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old female who has complaints by history of low back pain and radiculopathy. She had an on-the-job injury in xx/xx. She had lumbar spine surgery, decompression, and fusion at L4/L5 and L5/S1. She had the bone graft stimulator removed and the hardware removed and the fusion explored on 04/05/06, at which time it was stated that the fusion was solid. She was referred to Dr., who has recommended the procedure noted in the Disputed Services. Flexion and extension films do not demonstrate any instability at L2/L3 and L3/L4. She has documented on the MRI scan a grade 1 spondylolisthesis at L5 on S1 associated with spondylolysis of L5. There is a bulge at L3/L4, 1.5 cm, and a bulge as L2/L3 of 3 mm. She has had extensive conservative care.

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

It is the reviewer's opinion that medical necessity for the four-level spine surgery with fusion from L4 to S1 and decompression disc excision at L2 and L3/L4 with implantation of bone growth stimulator, examination under anesthesia, revision lumbar spine syndrome, discectomy, decompression arthrodesis post instrumentation, implantation of bone growth stimulator, and two-day hospital stay has not been determined as the fusion was only documented to be pseudoarthrotic on the left at L5/S1 and on the right at L4/L5.

The MRI scan that the patient underwent showed a grade 1 spondylolisthesis at L5/S1 at the level of the previous fusion, a posterior bulge at L3/L4 of 1.5 mm, and posterior bulge of 3 mm at L2/L3. There is no indication from the neurological examination that there is any neurologic deficit secondary to the disc herniation that would warrant decompression. The physician has documented decreased sensation at L5/S1 as well as positive straight leg raising, which would not be due to an L3 or L4 root. Diminished reflex at the knees, however, has been documented, but would not be an indication for surgery.

There is no documentation in the medical records of a pseudoarthrosis but rather the contrary, a unilateral fusion at the target levels. There is no indication for fusion of L5/S1 because of the spondylolysis, as there is no documented instability. The neurologic examination performed by the requesting surgeon demonstrates L5/S1 pathology in the form of numbness, and the laminectomies proposed at L2/L3 and L3/L4. These laminectomies are inextricably going to cause instability and without being fused. Indication for fusion at one to two levels is not supported by studies and protocols of the North American Spine Society and the American Academy of Neurological Surgeons. Hence, as the laminectomies are not being requested for the radicular complaints due to the disparate neurologic findings and the miniscule size of these bulges, the laminectomies/discectomies could not be of any clinical benefit. The fusion does not demonstrate instability, and there has been no documentation of any pain generator in association with either the discs that have not been previously operated upon or with the

alleged pseudoarthrosis that is not borne out by the medical records. It is for these reasons that these surgical procedures are not felt to be medically necessary.

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) North American Spine Society.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

