

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Pedicle screws and rods BMP intro operative fluoroscopy, posterior L4/5, L5/S1, decompression L4 sacrum interbody/lateral fusions with cages, and 3 day length of stay.

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

Board Certified Orthopedic 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

ODG Guidelines

Peer review, Dr., 10/09/07

Peer review, Dr., 10/31/07

CT lumbar, 07/27/07

Office note, Dr., 08/06/07

Physical therapy evaluation, 08/23/07

Office note, Dr., 10/02/07, 10/09/07

Behavioral assessment, 10/15/07

Addendum, Dr., 10/23/07, 11/07/07

Office notes, Dr., 10/25/07, 11/20/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old male truck driver was reportedly involved in a motor vehicle accident on xx/xx/xx and had immediate lumbar pain. A lumbar CT scan performed on xx/xx/xx showed a large disc herniation. An x-ray of the lumbar spine on 10/10/2007 showed significant L4-5 and L5- S1 narrowing, instability present at L4 and L5 and a grade 2 spondylolisthesis in flexion. The claimant was diagnosed with severe L4-L5 stenosis, significant L4 and L5 instability and markedly narrowed L4-5 and L5- S1 disc spaces. The records indicated that conservative care had included physical therapy, medication and an epidural steroid injection with reported an almost one-hundred percent relief of symptoms for several days. The treating physician has recommended a posterior two level decompression and fusion with a three day length of stay. Psychological testing on 10/15/07 noted the claimant an appropriate candidate for surgical intervention.

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

When one carefully evaluates this case, it has been less than five months since the injury in question. As such, six months of conservative care has not been failed. There is no documentation of a progressive neurologic deficit. Furthermore, the Reviewer's assessment is that it is critical to note that the most recent note of November 20, 2007 outlined 100 percent relief with an epidural steroid injection for a few days followed by persistent 60 percent relief. The physician recommends completion of the full epidural steroid series at that time.

At this point the Reviewer would agree with the determination of the insurance carrier that this should be a non certified procedure. As outlined above there is certainly nothing to suggest any form of progressive neurologic deficit to render surgical intervention urgent. It appears that the response to epidural steroids has been quite positive. There is no documentation of failure of six months of conservative care. For all of these reasons the Reviewer would uphold non certification.

Milliman Care Guidelines . Inpatient and Surgical Care 11th Edition.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back: Fusion.

Not recommended for patients who have less than six months of failed conservative care unless there is severe structural instability and or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled,

Patient Selection Criteria for Lumbar Spinal Fusion:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss

Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital unilateral neural arch hypoplasia.

(2) Segmental Instability - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy.

(3) Primary Mechanical Back Pain/Functional Spinal Unit Failure, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability, with and without neurogenic compromise. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered.

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)