

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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DATE OF REVIEW: July 17, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral decompression with foraminotomy at L3-4, L4-5, and L5-S1; fusion and instrumentation

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

Diplomate, American Board of Orthopaedic 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Provider include:

- M.D., 08/30/02
- Open MRI, M.D., 09/28/02

- Center, M.D., M.D., 10/31/02, 11/25/02, 11/30/02, 12/09/02, 12/10/02, 12/13/02, 12/18/02, 12/24/02, 01/27/03, 03/17/03, 03/27/03, 04/10/07, 04/26/07, 06/05/07, 06/07/07, 06/21/07
- C.A.T. Scan, M.D., 11/19/02
- M.D., 11/26/02
- Medical Center, M.D., 11/26/02, 12/13/02, 12/14/02
- Medicine Centre, 03/27/03
- Hospital –M.D., 06/11/06, 06/07/07
- M.D., 03/22/07
- M.D., 04/23/07

Medical records from the Carrier include:

- Inc., 05/15/07, 05/16/07, 05/17/07, 05/18/07, 06/05/07, 06/07/07, 06/08/07, 06/12/07, 06/13/07, 06/20/07, 06/25/07, 06/26/07, 06/28/07, 06/29/07
- M.D., 03/22/07
- Center, M.D., M.D., 04/10/07, 04/26/07, 06/05/07
- M.D., 04/23/07
- Company, R.N., 05/17/07, 06/07/07, 06/12/07

PATIENT CLINICAL HISTORY:

The records indicate a significant pre-existing condition, for which the patient underwent multilevel decompressions and foraminotomy, as well as repair of a tethered cord.

More recently, the patient slipped and fell, landing on her tailbone. Conservative measures including physical therapy, oral medications, and epidural injections were provided. Straight leg raising was intact. Deep tendon reflexes were intact as well.

M.D. subsequently recommended a CT myelogram that disclosed disc bulges at L3-4, with a spondylolisthesis of 5 mm at that level. Dr. recommended a fusion from L3 to S1 subsequently. It was reviewed by two peer reviewers and not found to be medically necessary, according to the ODG Guidelines.

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

July 17, 2007
Page 3 of 4

I reviewed the records in detail, as well as recent findings. It is my opinion as well that a fusion from L3 to S1 is not medically necessary with respect to evidence based medicine according to the ODG Guidelines.

The ODG Guidelines suggest that a spinal fusion is appropriate only in limited cases. It is not recommended for patients who have less than six months of failed conservative treatment unless there is severe structural instability or progressive neurologic dysfunction.

The AANS Guidelines indicate that a lumbar fusion is recommended for carefully selected patients with disabling low back pain due to one- or two-level degenerative disc disease.

I am in agreement with the peer reviewers who opined that a fusion from L3 to the sacrum is not indicated, as it would cause an exceptionally long lever arm to the degenerative L2-3 level. There is no evidence that the current surgery would improve the patient's condition over simple non-operative care.

Therefore, in summary, it is my opinion that the surgery being requested is not consistent with evidence based medicine, and is, therefore, not 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)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)