



DATE OF REVIEW: 6/1/07

MDR TRACKING #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity for the previously denied decompression/stabilization L4-5 segment/fusion/hardware/bone graft with two-day length of stay.

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

Texas licensed Orthopedic Surgeon.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Previously denied decompression/stabilization L4-5 segment/fusion/hardware/bone graft with two-day length of stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheet dated 5/23/07, 5/22/07, 5/21/07, 5/17/07, 5/16/07, 3/23/07, 2/1/07, 12/29/06, 8 pages.
- Notice to of Case Assignment dated 5/23/07, 5/17/07, 2 pages.
- Authorization Request dated 5/22/07, 1 page.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 5/17/07, 1 page.

- Confirmation on Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 5/16/07, 5 pages.
- Request for a Review by an Independent Review Organization dated 4/24/07, 2/16/07, 5 pages
- dated 4/3/07, 3 pages.
- Recommendation dated 3/12/07, 3 pages.
- Determination dated 2/7/07, 1/8/07, 4 pages.
- Demographics for dated 2/1/07, 12/29/06, 2 pages.
- Letter or Rebuttal dated 1/24/07, 1 page.
- Pre-authorization Form dated 12/29/06, 1 page.
- MRI Lumbar Spine dated 9/13/06, 7/22/05, 2 pages.
- Operative Report dated 12/14/06, 3 pages.
- Follow-up Visit dated 9/20/06, 8/17/06, 2/9/06, 5 pages.
- Radiographic Reading dated 2/9/06, 1 page.
- AP and Lateral with Flexion and Extension of the Lumbar Spine dated 6/29/05, 1 page.
- Request for Requesting Review by an Independent Review Organization (IRO) dated (unspecified), 6 pages.
- Reconsideration and Appeals Procedure Workers' Compensation dated (unspecified), 1 page.
- Peer Review Report dated (unspecified), 1 page.

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Patient's age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Not provided for review.

Diagnoses: Herniated nucleus pulposus L4-5 and radiculopathy L5-S1 (per EMG, 5/13/05).

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

On a 2/9/06 physician visit, the claimant was noted to have constant lumbar pain that was exacerbated by sitting, standing and bending, and somewhat relieved with medications. An examination revealed lumbar range of motion limited due to pain, and some decreased muscle testing. Sensation was intact in the left dermatomal pattern, and the claimant reported diminished sensation in the right. Lumbar surgery in the form of a L4-5 decompression and stabilization was recommended. An MRI of the lumbar spine was done on 9/13/06, which showed a disc herniation at L4-5 with moderate narrowing of the left neural foramen and impingement upon the exiting L4 nerve root. On a follow-up

physician visit dated 9/20/06, the claimant was noted to have continued low back pain. The claimant was advised to continue medications. An electromyogram (EMG) was recommended but denied by the insurance carrier, and a 12/14/06 discogram report was of poor quality and appeared to be negative. Peer reviews done on 1/2/07 and 2/1/07 denied the request for a lumbar decompression and fusion at the L4-5 level. In a letter of rebuttal from the attending physician dated 1/24/07, it was noted that the claimant had undergone conservative treatment since 2001, had significant pain and had not returned to work. According to the physician, both the lumbar MRI and the discogram supported the claimant's complaints. Lumbar surgery in the form of a decompression/stabilization L4-5 segment/fusion/hardware/bone graft with a two-day length of stay has been requested. Decompression/stabilization at L4-5 with segmental fusion, hardware and bone graft with two day length of stay does not appear to be medically necessary or reasonable. In review of the medical records available, the discogram noted on 12/14/06 appears to have been negative. The flexion/extension radiographs on 6/29/05 did not demonstrate significant instability translation on flexion or extension. An MRI on 7/22/05 and an MRI on 9/13/06 did not demonstrate any occult fracture and, most recently, the left disc herniation at L4-5 appeared to be lessened over that interval. There was no evidence of spinal fracture, dislocation, instability. It is not clear that the claimant is a good candidate for the proposed surgery from a psychological standpoint. The L4-5 fusion with a two-day length of stay cannot be recommended based on the information provided.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Low Back - Lumbar & Thoracic (Acute & Chronic) updated 5/30/07

- 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.