

Independent Resolutions Inc.

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DATE OF REVIEW:

JUNE 6, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar spine surgery with two-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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer reviews, 03/27/07, 04/05/07
Lumbar spine MRI, 07/14/04
Lumbar spine x-ray, 07/14/04
Office note, Dr., 07/22/04
Functional capacity evaluation, 10/05/04
Lower extremity EMG, 11/23/04
Lumbar spine MRI, 11/17/05
Office notes, Dr., 06/09/06, 09/13/06 and 01/25/07
Letter of medical necessity, Dr., 07/10/06
Myelogram, 11/03/06
Post myelogram CT scan, 11/03/06
Letter of medical necessity, Dr., 12/04/06
Office note, Dr., 11/15/06
Office note, Dr., 12/20/06
Surgical consultation, Dr., 02/06/07
Office note, Dr., 03/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant sustained a back injury on xx/xx/xx which resulted in back and bilateral leg pain. The records indicated that the claimant was diagnosed with multiple herniated nucleus pulposus and subsequently underwent a laminotomy and discectomy at L3-4, L4-5 and L5-S1 in 01/05. Following surgery, the claimant reportedly had persistent low

back and bilateral leg pain with bilateral lower leg paresthesias unresponsive to conservative care and was diagnosed with failed lumbar spine syndrome with recurrent herniated nucleus pulposus. Revision surgery in the form of a decompression discectomy at L3-4 and decompression discectomy and arthrodesis with internal fixation at the L4-5 and L5-S1 levels was recommended.

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

The claimant is a gentleman who apparently has had back and radicular leg complaints for a couple of years. He underwent on 01/20/05 laminectomy and discectomy at L3-L4, L4-L5 and L5-S1 for multiple disc herniations following a xx/xx/xx injury. Pre-operatively he had an EMG documenting a neurologic radicular abnormality. Post-operatively he continued to have pain and has undergone an 11/17/05 MRI documenting multiple level disc herniations as well as an 11/03/06 CT myelogram documenting multiple disc abnormalities. The claimant has been seen by a number of physicians and is currently under the care of Dr., Orthopedic Spine Surgeon, who on 02/06/07 in an office note described structural instability of his x-rays of the lower lumbar spine with 16 degrees of angular change at different levels on flexion/extension stress x-rays. Examination at that time showed spasm, a positive straight leg raise and neurologic abnormality to both lower extremities and he felt that this was a failed lumbar spine syndrome with recurrent disc herniations at L3-L4, L4-L5 and L5-S1 with loss of motion segment integrity and instability of L4-L5 and L5-S1.

The Reviewer has reviewed the previous peer reviews of 03/27/07 and 04/05/07 and does not agree with the previous reviews. The Reviewer believes Dr. has written a very clear 02/06/07 note documenting the patient's failure of previous operative treatment, new diagnostic tests showing disc herniation and structural instability as well as positive physical findings documenting a neurologic abnormality. Due to all of this together, which indicates a failure of conservative care following his first operative procedure, that the requested revision decompression discectomy of L3-L4 with decompression discectomy and fusion of L4-L5 and L5-S1 with a two-day length of stay is medically reasonable and necessary at this time based on the records I have for review.

Official Disability Guidelines, Treatment in Worker's Comp, 2007 Updates, Low Back Chapter, Lumbar Spinal Fusion Section;

Patient Selection Criteria for Lumbar Spinal Fusion:

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

Milliman Care Guidelines, 11th Edition, 2007, Inpatient and Surgical Care

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**
 - Milliman Care Guidelines, 11th Edition, 2007, Inpatient and Surgical Care.
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
 - Official Disability Guidelines, Treatment in Worker's Comp, 2007 Updates, Low Back Chapter, Lumbar Spinal Fusion Section;
- 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)**