

**IRO NOTICE OF DECISION TEMPLATE – WCN**

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**IRO REVIEWER REPORT TEMPLATE – WCN**

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**DATE OF REVIEW:** March 12, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Exploration of fusion, hardware removal 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**

Myelogram, 11/03/06  
CT scan noted, 11/03/06  
Office note, Dr., 11/07/06, 11/21/06  
Office note, Dr., 12/08/06  
Office note, Dr. , 12/21/06  
12/29/06 and 01/16/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female with a history of a previous L4-5 fusion done in 2001. She apparently reported injuring her low back pushing cargo. She has had chiropractic treatment for her complaints.

On the 11/03/06 myelogram there was a 360 degree fusion at L4-5. There was markedly limited range of motion of the lumbar spine in flexion and extension. Mild chronic wedge deformity of the L1 vertebra was seen. Anatomic position of the 360 fusion with no evidence of complication was documented. The follow up CT showed a large amount of scar tissue and epidural fibrosis filling the entirety of the bilateral lateral recesses surrounding both the L5 nerve root sheaths with findings worse on the left and mild thickening around the S1 nerve root sheath

On the 11/07/06 visit Dr. did not have the films but felt that the report did not indicate surgery was necessary. He also noted that he had concerns about the claimant and her disability status. Her examination revealed only tenderness. When Dr. could not explain the symptoms, he requested that CT myelogram be re-read. The lumbar CT myelogram was re-read by Dr., neuroradiologist, on 12/08/06. His final impression of the study was a solid fusion with otherwise normal findings.

The claimant came under the care of Dr. on 12/21/06 for back and right leg pain for 6 months. On examination reflexes were 2+. Tension testing caused back and right posterior thigh pain. There was tenderness to palpation of the pedicle screws. Dr. felt that the pedicle screws were the source of pain and recommended exploration of the fusion and removal of hardware.

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

The records provided do not support the request for surgery as proposed. In review of the file, there are some concerns. The claimant does have a history of depression and there were concerns expressed by Dr. as to her motivation. There has been no documentation of psychological screening having been done to determine if there are secondary gain issues. In addition, the records do not clearly establish the hardware is the pain generator for this claimant. There has been no diagnostic hardware block performed. Removal of the hardware in this instance may not predictably relieve her pain.

**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)
  - Simeone and Rothman. The Spine Fifth Edition, Chapter 93; pg 1544