

Clear Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW: NOVEMBER 9, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal surgery, two-day length of stay

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

M.D., board certified Orthopedic Surgeon, board certified by the American Board of Spinal 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

Adverse Determination Letters, 10/2/07, 10/19/07
ODG, Low Back – Lumbar & Thoracic (Acute & Chronic)
Letter from Patient, 10/24/07
Dr., 6/14/07, 4/5/07, 1/8/07, 1/30/07, 2/7/07,
Dr., Operative Report, 6/1/07
Dr., 3/28/07, 7/19/07, 8/6/07, 9/19/07, 10/11/07
Lumbar Myelography, 7/18/07
MRI scan, Dr., 1/3/07
Dr., 2/28/07
Dr., 1/10/07
Prescription Medication List, 3/20/07
Dr., D.C., 1/2/07, 1/5/07
Dr., D.C., 1/10/07

Lumbar Post Discogram CT scan, 8/30/07
RN, 9/10/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when he was, according to history, moving some pipe clamps from a joint. He had a twisting and rotating injury to his back. He states that once he did it, he had pain and discomfort in his back and down his legs. The pain is stated to go down both legs. Standing hurts him. Apparently he heard a pop at the time of the accident. He has undergone conservative treatment including physical therapy, epidural steroid injections, myelogram, MRI scan, and a discogram. The studies reveal in combination that at L3/L4 he has a large 4 mm to 5 mm left-sided disc protrusion. At L4/L5 there is some reduction of interspace but with only spondylitic ridging. At L5/S1 there is a posterior marginal body osteophytic ridge with symmetrical annular bulge. The MRI scan also showed an L2/L3 extruded disc with a herniation along with the other findings. The EMG/nerve conduction study showed bilateral L4 and L5 radiculopathy. The discogram with postdiscographic CT scan revealed herniated disc with extrusion at L2/L3 and L3/L4. At L4/L5 there was loss of disc space height. At L5/S1, there was no discogram performed. At L2/L3, L3/L4, and L4/L5 there was grade 5 appearance of the annular tears. Various neurological pictures have been documented in the chart, some revealing weakness of the S1 root, others paresthesias into the right leg encroaching on L4 and L5 distribution.

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

This patient has multilevel disc disease with the worst levels at L2/L3 and L3/L4. There is minimal stenosis noted on the various studies, and the diagnosis based upon EMG/NCV study is bilateral L4/L5 disc herniation. Recommendation has been to perform a fusion at L4/L5 and L5/S1 and microdiscectomy along with a neuroforaminotomy at L3/L4. In a patient with multiple levels of pathology, in this case four levels, the reason for the decision to perform only the lower two levels is unclear. Certainly the largest disc extrusions are at L2/L3 and L3/L4. The reason for the use of the spinal extension limiting device is unclear, and there is little data to support its long-term efficacy.

Performing a two-level fusion for the L4/L5 radiculopathy, which is only clearly identifiable on the EMG/nerve conduction study, is also of some concern. The ODG Guidelines would clearly not support surgery in this particular patient. The guidelines do recognize in carefully selected patients the use of fusion for one-level or two-level degenerative disc disease after an appropriate period of conservative care. This gentleman has received an appropriate period of conservative care, but he has clear-cut four-level disease. With a herniated disc at the two levels above the proposed fusion level already in evidence, it is unclear as to how a two-level fusion below this level could be of any benefit. At the very least, it will place increased stress upon the levels above, and the discogram has clearly confirmed that his pathology is not isolated to the lowest two motion segments.

Hence, based upon the ODG criteria and general knowledge of the spinal literature not showing good outcomes in patients, (and particularly Workers' Compensation patients) with more than one-level or two-level fusion for isolated disc problems, we do not feel that this recommended procedure has a good chance of any long-term benefit. In summary, therefore, the requested two-level lumbar fusion is not considered medically necessary based upon the review, and the two day post surgical stay would not be medically necessary as the surgery itself is not medically necessary in the opinion of this reviewer.

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) North American Spine Society Guidelines