I-Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Fusion L5-S1 w/1 Day LOS

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

MD, 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.

The reviewer finds that medical necessity does not exist for Lumbar Fusion L5-S1 w/1 Day LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 07/02/08, 07/24/08
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back. Fusion.
X-ray lumbar spine, 01/03/07, 07/14/08
MRI lumbar spine, 01/03/07
EMG/ NCS, 01/31/07
Lumbar myelogram / CT, 01/08/08
DDE, Dr. , 05/08/07

Office note, Dr. , 11/06/07
Office notes, Dr. , 12/13/07, 01/05/08, 02/14/08, 03/18/08, 04/24/08, 06/24/08
Letter from Dr. , 07/15/08
UR review, 06/30/08
Psychological surgery release, undated

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old claimant diagnosed with a herniated nucleus pulpous L5- S1. The records indicated that the claimant felt a "pop" in his back on xx/xx/xx while lifting a gas cylinder weighing approximately thirty – five pounds. Lumbar x-rays showed moderate narrowing of L5 disc interspace throughout. A lumbar MRI performed on 01/03/07 showed a left central disc herniation at L5- S1 and displacement of the traversing left S1 nerve. There was also a far lateral disc bulge at L4-5. An EMG/NCS followed on 01/31/07 which revealed evidence of active lumbar radiculopathy L4-5 and S1.

The claimant continued to report low back pain and numbness in both legs. Conservative care included medications, physical therapy, chiropractic care and light duty. On examination, there was weakness noted, tenderness and decreased bilateral ankle jerk. On a 01/05/08 physician visit, continued low back pain was noted. A review of a lumbar myelogram and CT indicated a disc herniation at L5- S1 and evidence of neuroforaminal narrowing and lateral recess narrowing as a result of the disc herniation. A 02/14/08 physician visit, noted the claimant had had a psychological evaluation and was found to be depressed over the health issues and was not sure he wanted to have surgery. Continued counseling was advised. The claimant was unable to work due to pain. On a 06/24/08 follow up visit, persistent low back pain and right greatest than left leg pain was noted. It was also noted that the claimant had continued psychological counseling and was felt to be a good candidate for surgery. Lumbar x-rays done on 07/14/08 showed anterior translation of L5 on S1 and loss of disc height at L5- S1 with a posteroinferior osteophyte formation. The treating physician recommended a lumbar fusion L5- S1 with a one day length of stay.

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

It is clear from the medical records that this young claimant does not have spondylolisthesis or any documented instability. There is no documentation of a progressive degenerative change. There is no prior surgery. He does not meet the criteria in the ODG Guidelines for Fusion. In addition, the psychosocial follow-up states that a prolonged course was documented, and then it appears that rather “suddenly” the patient has become a good candidate for surgery. Due to the patient not meeting the ODG criteria and the psychosocial evaluations, the reviewer agrees with the prior determination in this case. The reviewer finds that medical necessity does not exist for Lumbar Fusion L5-S1 w/1 Day LOS.

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)**