

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

22612 Lumbar Spine Fusion, Posterolateral, 22630 Lumbar Spine Fusion, Post Interbody at L5-S1, 22840 Insert Spine Fixation, Posterior; 22851 Apply Spinal Prosthetic Device; 63047 Remove Lumbar Spine Lamina 1 Seg & 63048 Remove Added Spine Lamina 1 Segment

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 22612 Lumbar Spine Fusion, Posterolateral, 22630 Lumbar Spine Fusion, Post Interbody at L5-S1, 22840 Insert Spine Fixation, Posterior; 22851 Apply Spinal Prosthetic Device; 63047 Remove Lumbar Spine Lamina 1 Seg & 63048 Remove Added Spine Lamina 1 Segment.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/27/08, 8/5/08
ODG Guidelines and Treatment Guidelines
Lumbar Spine Series, 4 Views, 9/21/07

MRI of Lumbar Spine, 8/1/07
MD, 7/24/08, 5/22/08
Designated Doctor Examination, 1/24/08
7/30/07
FCE, 9/5/07
EMG, 8/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This worker was injured on xx/xx/xx. He apparently has a 9-mm broad based disc bulge at L5/S1 with grade 1 spondylolisthesis, which is stable. He has an EMG/nerve conduction study reporting a left S1 radiculopathy. He also has weakness of his L5 root on physical examination stated to be 4+/5 on the left. His reflexes are apparently intact. He also is stated to have a left iliopsoas weakness at 4+/5. He has no spasm in the lumbar area and no lumbar tenderness. His complaints appear from the medical records to be entirely radicular, and there has been a previous recommendation of an L4/L5 laminectomy. There is no explanation of why his neurological picture does not correspond to the clinical physical examination, and there is no explanation of why decompression of the roots would not be of value, given the absence of axial pain and physical signs.

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

Based upon current medical judgment and experience as well as the ODG Guidelines and evidence-based medicine, fusions are generally not recommended in primary cases such as this with pure radicular symptoms and no instability. It is for this reason that the previous adverse determination is upheld. In this case there is a discrepancy between the physical examination and the EMG/nerve conduction study. The medical records demonstrate that this "bulge" is large at 9 mm and may be the cause of problems to the exiting root as well as the traversing root. The grade 1 spondylolisthesis is stable based upon flexion and extension views, and hence it is hard to justify a fusion in this particular incidence. Based upon this absence of instability, the discrepancy between the EMG/nerve conduction studies, and the physical examination, this reviewer upholds the previous adverse determination. The reviewer finds that medical necessity does not exist for 22612 Lumbar Spine Fusion, Posterolateral, 22630 Lumbar Spine Fusion, Post Interbody at L5-S1, 22840 Insert Spine Fixation, Posterior; 22851 Apply Spinal Prosthetic Device; 63047 Remove Lumbar Spine Lamina 1 Seg & 63048 Remove Added Spine Lamina 1 Segment.

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)