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Notice of Independent Review Decision

DATE OF REVIEW: 12/30/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient excision of internal fixation at L4-L5, re-do decompression on the left at L5-S1, evaluation of fusion, and intraoperative decision for transverse process fusion at L4-L5 with additional level at L5-S1 fusion with a two day length of stay

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

Board Certified in Orthopedic 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)

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.

Inpatient excision of internal fixation at L4-L5, re-do decompression on the left at L5-S1, evaluation of fusion, and intraoperative decision for transverse process fusion at L4-L5 with additional level at L5-S1 fusion with a two day length of stay
- Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by , M.D. dated 07/19/06
A lumbar CT scan interpreted by , M.D. dated 03/05/07
An operative report from , M.D. dated 01/29/08
Evaluations with Dr. dated 06/25/08, 08/13/08, 08/20/08, 11/14/08,
A procedure note from , M.D. dated 07/23/08
An evaluation with , D.O. dated 08/12/08
An EMG/NCV study interpreted by Dr. dated 08/12/08
MMPI testing with Dr. (no credentials were listed) dated 09/25/08
A letter of non-certification, according to the ODG, from , M.D. dated 11/17/08
A letter of non-certification, according to the ODG, from , M.D. dated 12/02/08
The ODG Guidelines were provided by the carrier

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 07/19/06 revealed degenerative disc disease at L4 through S1, a disc herniation at L4-L5, and spondylosis at L5. A lumbar CT scan interpreted by Dr. on 03/05/07 revealed spondylosis at L4-L5 and L5-S1, disc bulging at L4-L5, and a disc protrusion at L5-S1. On 01/29/08, Dr. performed a total discectomy and interbody fusion with fixation. On 06/25/08, Dr. recommended a hardware block and continued Lyrica. A hardware block was performed by Dr. on 07/23/08. An EMG/NCV study interpreted by Dr. on 08/12/08 revealed left L5 radiculopathy. On 08/13/08, Dr. recommended a redo surgery. On 09/25/08, Dr. felt the patient was a good candidate for the surgery. On 11/17/08, Dr. wrote a letter of non-certification for the lumbar surgery. On 12/02/08, Dr. also wrote a letter of non-certification for the lumbar surgery.

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

Removal of hardware is extremely controversial as a method of pain control. It is extremely unreliable. Hardware blocks do not elucidate the source of ongoing symptoms. This patient is significantly depressed, which would indicate that objective end dates of treatment is not likely to lead to significant improvement, despite the psychologist's optimistic report. There is no objective imaging that demonstrates whether the patient has a fusion, a non-union, or neural impingement that corresponds to the rather dubious EMG findings. In the absence of an objective indication for surgery, one cannot justify further invasive treatment. Therefore, the requested inpatient excision of internal fixation at L4-L5, re-do decompression on the left at L5-S1, evaluation of fusion, and intraoperative decision for transverse process fusion at L4-L5 with additional level at L5-S1 fusion with a two day length of stay is neither reasonable nor necessary.

**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 AND KNOWLEDGE BASE
- 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)