

# Clear Resolutions Inc.

**An Independent Review Organization**

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Notice of Independent Review Decision

**DATE OF REVIEW: DECEMBER 8, 2008**

**IRO CASE #:**

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

Lami/Disc L5-S1, Exploration of Fusion L3-4, L4-5

**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 Lami/Disc L5-S1, Exploration of Fusion L3-4, L4-5.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 11/4/08, 11/12/08  
ODG Guidelines and Treatment Guidelines  
Surgery Scheduling Slip, 9/26/08  
Dr. MD, 9/26/08  
COPE, 10/27/08  
DO, 9/4/08, 7/31/08, 7/1/08, 3/25/08, 1/28/08, 11/9/07, 9/20/07, 7/6/07, 5/18/07, 4/5/07  
Operative Report, 9/6/07  
Radiology Reports, 5/11/07, 4/3/07  
Back Institute, Patient Profile, 9/29/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker who is reported to have had an anterior lumbar fusion at L3/L4 and L5/S1 with apparently good results for approximately a ten-year period. He returns with complaints of low back pain and radiating leg pain. The patient is xx years old. The current injury of xx/xx/xx reports upon evaluation an apparent solid fusion and no fracture, some lumbar tenderness, right-sided straight leg raising, semi-antalgic gait, intact reflexes strength and limited range of motion. There is a report of decreased sensation variably over the S1 dermatome and over the L5/S1 dermatome.

MRI scan on 05/11/08 revealed an L5/S1 small central disc protrusion, which apparently contacted the right S1 nerve sleeve and some facet arthrosis at L2/L3. The patient underwent a series of epidural steroid injections with transient relief from the first two and none from the third. There is an indication there is some numbness along the lateral side of his foot as well as the dorsum of the foot. The patient has had medications including Ambien, Flexeril, Celebrex, and Vicodin. Previous physician recommended microdiscectomy at the L5/S1 level. The previous lumbar fusion was apparently with anterior fusion cages at L3/L4 and L4/L5 with subsidence of the L3/L4 cage into the L3 vertebral body. The patient had a preoperative psychological screening, which he passed without problems.

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

Based on the medical records provided to this reviewer, nowhere in the medical records is there any substantiation for the medical necessity of fusion exploration. There is no severe radiculopathy at this time documented such as bowel and bladder problems and muscle weakness. The reviewer finds that medical necessity does not exist for Lami/Disc L5-S1, Exploration of Fusion L3-4, L4-5.

**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)