

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 23, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of anterior lumbar interbody fusion transsacral approach with posterior facet joint stabilization. (L5-S1)

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

M.D., 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 there is not medical necessity for anterior lumbar interbody fusion transsacral approach with posterior facet joint stabilization. (L5-S1)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/21/08, 5/2/08
Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back MRI lumbar spine report, 2/12/07
Office notes, Dr. 03/05/07, 07/16/07, 08/23/07, 03/19/08
EMG, 04/1907

Operation, 07/18/07
MRI lumbar spine, 10/23/07
Psychological evaluation, 04/07/08
Dr. 04/18/08
Dr. 06/06/08
Letter, Dr. 4/18/08
Behavioral medical evaluation, Dr. 06/21/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who was status post xx/xx/xx lumbar laminectomy discectomy foraminotomy, partial facetectomy at L5-S1. The claimant continued to complain of low back pain. The 10/23/07 MRI of the lumbar spine showed a residual focal disc bulge at L5-S1 contacting the transversing right S1 nerve that appeared to have some degree of perineural fibrosis on the medial and anterior aspect of the nerve and it was slightly enlarged with subtle enhancement probably representing some degree of radiculitis. Broad based left posterolateral foraminal disc bulge contacting the inferior margin of the exiting left L4 nerve was noted. Laminectomy right L5 lamina with residual soft tissue changes was noted. The claimant underwent a behavioral evaluation on 06/21/08 which recommended that the claimant was a fair to good candidate for surgery but also recommended a pain management program.

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

The requested anterior lumbar interbody fusion transsacral approach with posterior facet joint stabilization. (L5-S1) is not medically necessary based on review of these medical records.

It would appear that the claimant had a right L5-S1 disc herniation displacing the traversing right S1 nerve root. She was treated conservatively and underwent an EMG documenting a right S1 radiculopathy. She underwent a 07/18/07 L5-S1 lumbar disc excision and foraminotomy. Postoperatively, she had residual and progressively worsening symptoms.

She underwent a 10/23/07 MRI of the lumbar spine whose report describes a focal disc bulge contacting the S1 nerve root with scar tissue, and she continued to treat with Dr. who documented ongoing positive physical findings of sensation change and pain complaints.

There is some discussion in the medical record as to whether or not the quality of her psychologic evaluation was good, and she underwent a repeat psychologic evaluation on 06/21/08 that does not appear to have felt that she was a surgical candidate, yet instead described the need for a pain management program. Critical review of the postsurgical 10/23/07 MRI of the lumbar spine report describes a disc bulge and scar tissue, but not a new disc herniation.

While a large recurrent disc herniation following primary disc excision can often be treated with redo disc surgery and fusion for stability, it is a second operative procedure

at the same level, in this case, and there is not a large disc herniation but just a bulge and scar, and the psychologic evaluator did not feel she was a good candidate for surgery. In addition, guidelines indicate that there should be spinal instability and a psychologic screen with confounding issues needs addressed, yet that does not appear to have occurred in this case.

Therefore, in light of the fact that there does not appear to be a significant sized recurrent disc herniation, there is not evidence of progressive neurologic deficit, and there is really no difference in her physical findings now than were there prior to her first surgical procedure, and the fact that the second psychologic evaluator did not feel she was a surgical candidate, but instead recommended pain management this requested surgical intervention does in fact not seem to be medically indicated.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back
Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) (BlueCross BlueShield)

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
- AHCP- 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)**