

## **I-Decisions Inc.**

*An Independent Review Organization*

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 06/24/2008

**IRO CASE #:**

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

Spinal Surgery (LOS)

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

Board Certified Neurosurgeon with additional training in Pediatric Neurosurgery

### **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)

Upon independent review the reviewer finds that the requested Spinal Surgery (LOS) is not medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 4/22/08, 5/8/08

ODG Guidelines and Treatment Guidelines

MD, 5/14/08, 4/1/08, 2/25/08, 1/15/08, 12/5/07, 11/16/07, 10/30/07, 9/20/07, 5/8/07, 4/3/07, 2/20/07

Facet Block, 11/27/07

PARS Block, 10/5/07

Operative Report lumbar myelogram, 3/19/07

EMG/NCV, 12/28/06

MRI Report, 12/21/06, 6/22/06

Lumbar ESI, 10/5/07  
MD, 6/4/07, Psych Eval  
Radiology Report, Lumbar Myelogram and post-myelo CT, 3/19/07  
MD, 4/25/94, 4/18/95, 7/19/94, 10/25/94, 11/19/93, 7/18/95, 2/15/94, 2/14/94, 12/9/96,  
1/15/96  
Lain films of the lumbar spine report, 4/18/95  
Bone Scan, 7/28/93  
Workers' Compensation Discharge Report, MD, 2/2/95-2/17/95  
Medical Associates, 1/12/07  
Hospital, Dr. MD, 1/19/94  
Initial Evaluation, Dr., MD, 5/17/93  
SP Nerve Block Single L, 1/29/07  
SP Nerve Block Inj. Lumb, 1/29/07  
Dr. clinic note 01/09/2007

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured male with a history of an L5-S1 fusion in xxxx. He complains of severe low back pain that radiates into his left anterior and posterior thigh to his calf from an injury on xx/xx/xx. He has had physical therapy and epidural steroid injections. Neurological examination reveals mild weakness of the left tibialis anterior. A myelo CT reveals facet arthropathy at L5-S1 and a pars defect at L5-1 on the left. . An EMG/NCV 12/28/2006 showed a left L5 radiculopathy. The patient has had epidural steroid injections. A psychological evaluation was done, but full testing was not done, due to the language barrier. However, no further psychological treatment was recommended, and his mild depression was believed to be situational. The provider is recommending an L5-S1 PLIF and LSO brace.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested spinal surgery (LOS) is not medically necessary. The patient has already had an L5-S1 fusion in 1994. It is not clear why he needs another fusion at the same level. There is no mention of a pseudoarthrosis or any instability. No flexion and extension films were done. Most of the clinic notes states he has had a prior laminectomy at L5-S1, but the operative report from 1994 clearly states that he underwent an intertransverse (posterolateral) fusion. Some of the postoperative notes in 1994 and 1995 also make note that the fusion looks solid on post-operative x-rays. Therefore, it is unclear why a repeat fusion at the same level needs to be done. According to the ODG, "Low Back" chapter for criteria of lumbar fusion, "**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". In this case, it is not clear that the appropriate pain generator have been identified. Since the surgery is not medically necessary, the LSO brace is also not medically necessary.

### **References/Guidelines**

ODG, "Low Back" chapter

**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)