

I-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

Laminectomy, Facetectomy and Foraminotomy (Unilateral or bilateral with decompression of S)

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

M.D., board certified Orthopedic Surgeon, Spine 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 Laminectomy, Facetectomy and Foraminotomy (Unilateral or bilateral with decompression of S).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/30/08, 5/27/08, 6/16/08

ODG Guidelines and Treatment Guidelines

Letter to IRO, 6/18/08

MD, 6/5/08, 5/30/08, 5/15/08, 4/24/08, 3/9/05, 3/13/08, 1/15/08, 8/4/04, 7/20/04, 9/4/07, 6/5/07, 3/8/07, 1/9/07, 10/26/06, 8/14/06, 3/17/06, 12/6/05, 8/30/05, 3/17/05, 2/10/05, 2/22/05, 9/20/05, 11/1/05, 3/28/05, 4/28/05, 6/2/05, 7/7/05, 3/14/05, 5/11/06, 7/10/06, 1/9/06, 2/9/06, 8/3/04, 8/12/04, 8/19/04, 9/9/04, 10/7/04, 11/23/04, 12/28/04, 1/6/05 Esq., 5/22/08

Lumbar Spine, 2 views, 8/4/04
XRay, 9/15/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who had a previous herniated disc at L4/L5 and L5/S1. He has undergone two previous lumbar procedures. He now comes in complaining of pain. He has noted he has pain radiating to both lower extremities with straight leg raising positive at 35 degrees on the right and 40 degrees on the left. The MRI scan currently does not reveal such nerve root compression. He is noted to have severe degenerative changes at the L5/S1 level with a grade 1 anterolisthesis. He has had physical therapy. As noted, plain x-ray showed grade 1 anterolisthesis, L5 on S1. MRI scan of the lumbar spine showed advanced degenerative changes at L5/S1 with facet hypertrophy. At L4/L5 there was minimal disc bulging and facet arthropathy without central canal stenosis or recurrent herniation. In review of the medical records, the pain generator has not been actuated in this individual. Previous reviewer has questioned the necessity to include the L4/L5 level in the fusion.

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

The anterolisthesis at L5 on S1 has not been identified as being significantly unstable, and the L4/L5 level has not been identified as being a pain generator. Provocative discography has not been performed in this individual. The reviewer is unable to determine whether or not the fusion of the L4/L5 and L5/S1 levels will result in any pain relief. Certainly this request does not conform to ODG Guidelines where: (1) all pain generators are identified and treated; (2) all physical medicine and manual therapy are completed; (3) x-rays demonstrating spinal instability under myelogram, CT myelogram, or discography and MRI scan demonstrating disc pathology; (4) spine pathology limited to two levels; (5) psychological screening with confounding issues addressed; (6) for any fusion surgery, cessation of smoking six weeks prior to the operation. In this case, given that the pain generator has not been identified, spinal instability has not been documented, pain generator using discography or instability has not occurred, disc pathology at the L4/L5 level has not been adequately addressed, and psychological issues ruled out, this patient does not meet the ODG criteria for the requested procedure. The reviewer finds that medical necessity does not exist for Laminectomy, Facetectomy and Foraminotomy (Unilateral or bilateral with decompression of S).

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)