

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 5/19/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from Johns Hopkins U (1996, MD) and completed training in Orthopaedics at The University Health System of Pittsburgh. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopaedics since 2004.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in |

part/Disagree in part) Spinal Surgery Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a XX year old male. According to notes provided, the injured employee experienced an onset of back pain after lifting a heavy unit onto a dolly on XX/XX/XX. He underwent a decompression laminectomy and posterolateral fusion on 06/26/2002. He did not recover and did not return to function.

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

According to the medical records provided the claimant is status post discectomy at L4-5 in 1995, status post fusion at L3-4 and L4-5 in 2002, posterior fusion L3-4, L4-5, L5-S1 with pseudoarthrosis at L5-S1 in the past. Past medical history was significant for depression and positive smoking history.

The records reviewed support Dr. did a Required Medical Exam (RME) on 01/31/2007 and felt the fusion had healed with no residual nerve root injury. He felt the present symptoms appeared to be psychosocial and may continue indefinitely as he complained of pain, tenderness, decreased range of motion with straight leg raise negative. Radiographs were unimpressive.

The claimant saw Dr. on 02/06/2008. He noted complaints of pain and treated him with methadone, Soma, and a spinal cord stimulator was discussed. He saw Dr. on 02/06/2008 who recommended a home exercise program and an L5-S1 decompression and extension of fusion at L5-S1 and continue with medications.

The claimant saw Dr. for evaluation for surgery on 02/07/2008. He noted decreased range of motion, complaints of pain, straight leg raising negative. The hardware was in place without loosening or shifting. He felt there was spotty bone consolidation and recommended a CT myelogram.

The CT myelogram on 02/26/2008 showed a pseudoarthrosis at L5-S1, noted his developmental variation was normal, satisfactory appearance of posterior fusions L3-4, L4-5, and L5-S1 and status post laminectomies, otherwise unremarkable. Dr. felt that L5-S1 was the legitimate source of pain and recommended anterior approach, bone grafting for stabilization and combination decompression stabilization, inpatient.

The request is for an anterior posterior lumbar fusion L5-S1, iliac crest bone graft, instrumentation, hardware removal with four day length of stay cannot be recommended as medically necessary. There is no documentation of motion segment instability and no flexion/extension views to confirm the same. There is no evidence of progressive neurologic deficit on examination. There is no documentation that the claimant has stopped smoking. There is no documentation that the claimant has failed to exhaust conservative measures recently for relief of symptomatology, including physical therapy, anti-inflammatory medications, pain medications, or epidural steroid injections. There appears to be psychosocial overlay as noted by Dr. 's note of 01/31/2007. There is no documentation that the claimant went for consultation for a psychosocial evaluation to assess for any overlay or onlay issues. Based on all the above, the proposed surgery cannot be recommended as medically indicated and necessary. Therefore, the previous denial is upheld.

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
- X** 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)