

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of Inpatient stay times three days, lumbar L5-S1 laminectomy/facetectomy TLIF Cage with BMP, posterior lateral fusion with instrumentation.

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 Inpatient stay times three days, lumbar L5-S1 laminectomy/facetectomy TLIF Cage with BMP, posterior lateral fusion with instrumentation.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr. , 05/02/07

Office note, , PhD, 07/09/07

Office notes, Dr. , 10/18/07, 12/18/07, 04/03/08, 05/22/08

Lumbar MRI, 04/30/08

Peer review, Dr. , 06/30/08

Letter to insurance, Dr. , 07/25/08
Adverse Determination Letters, 7/7/08, 08/05/08
ODG Guidelines and Treatment Guidelines, Fusion

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old male with low back pain and leg pain. Dr. saw the claimant on 04/03/08. The claimant reported the 2nd injection provided three weeks of benefit. Right leg strength was 4-5. His gait was antalgic. The diagnosis was lumbar herniated disc with failed conservative management. Lyrica was refilled. The 04/30/08 lumbar MRI showed disc dessication with disc height loss at L5-S1. There was a focal left posterolateral disc protrusion at L5-S1 with effacement of the left lateral recess and impingement on the descending left S1 nerve root. Bilateral neural foraminal narrowing at L5-S1 secondary to disc bulge and facet joint degenerative changes with impingement on the exiting left L5 nerve root was noted. Dr. reviewed the 04/30/08 lumbar MRI on 05/22/08 and felt that it showed a herniated disc at L5-S1 centrally towards the left with compression of the left L5 nerve root. Dr. recommended a L5-S1 laminectomy, facetectomy, transforaminal lumbar interbody/arthrodesis with interbody cage with BMP, posterolateral fusion with pedicle screw instrumentation.

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

The requested L5-S1 laminectomy, facetectomy, and fusion with instrumentation and three day length of stay is not medically necessary based on review of this medical record.

While this claimant has degenerative disc disease at L5-S1, the record also goes on to document a left-sided foraminal disc protrusion impinging on the left S1 nerve root; however, the claimant primarily has right leg pain, which does not specifically correlate with his diagnostic studies. There is also no documentation of structural instability.

The 04/30/08 lumbar MRI documents foraminal narrowing, bilateral L5-S1, but only impingement on the exiting left L5 nerve root, and, again, the record does not specifically discuss exactly why this person has right leg symptoms.

In light of the fact that diagnostic testing does not line up and correlate with the subjective complaints and physical findings, the reviewer has determined that the requested surgical intervention is not medically necessary. The reviewer finds that medical necessity does not exist for Inpatient stay times three days, lumbar L5-S1 laminectomy/facetectomy TLIF Cage with BMP, posterior lateral fusion with instrumentation.

Official Disability Guidelines Treatment in Workers' Comp 2008 Updates, low back-spinal 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; & (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](#)).

Milliman Care Guidelines, Inpatient Surgery, 12th Edition

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)