

# Clear Resolutions Inc.

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## DATE OF REVIEW:

Jun/22/2009

## IRO CASE #:

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

2 Day Inpatient LOS with lumbar surgery with examination under anesthesia, Lumbar Laminectomy, Discectomy, Arthrodesis with Cages, Posterior Instrumentation, and Implantation of a Bone Growth Stimulator (EBI) at L4-5-S1

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

M.D., board certified in Orthopedic Surgery  
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)

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Determination Letters, 5/29/09, 5/18/09

List of surgery codes

Dr. MD, 5/5/09, 3/24/09, 12/9/08,

MR Lumbar Spine with flexion and extension, 10/16/07

NCS/EMG Report, 10/23/07

Behavioral Health Assessment, 2/9/09

Dr. MD, 9/8/08

Counseling Center, 1/13/09

Peri-Operative Mental Health Evaluation, Goals/Plan/Justification, undated

Progress Note, 12/8/08, 11/3/08, 8/20/08, 7/30/08, 7/9/08, 6/18/08, 8/29/07

## PATIENT CLINICAL HISTORY SUMMARY

This is a female injured on xx-xx-xx when she fell off a porch. She has been treated with therapy, hydrocodone, Zanaflex, and Lodine. She is post cervical spine reconstruction on 3/11/09. Lumbar MRI scan showed L3/L4 annular disc bulge. At L4/L5 there was a broad-based subligamentous disc herniation, which was causing some central stenosis with bilateral foraminal stenosis. At L5/S1 there is a 4-mm subarticular disc herniation that flattened the thecal sac and compromised the left S1 root. The EMG on 10/23/07 showed L4 to S1 radiculopathy bilaterally. On examination she shows findings of pain, decreased range of motion, and apparently a seated straight leg raise was positive. She has had

recommendations for epidural steroid injection. Flexion/extension views, while showing on bone-on-bone disc space, perhaps do not show any translation or rotation. Discogram and post discogram CT scan have not been achieved. She has had psychological evaluation, which shows significant psychological stressors. She smokes a pack a day.

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

The patient does not satisfy ODG screening criteria for these procedures at a number of levels. First, she does not have instability as per the criteria. Second, she is a smoker. Third, the records indicate she has significant psychological problems. There is no evidence in the medical literature that the adjunct of fusion to decompression and degenerative stenosis is of any benefit. She has not had discogram or post discographic CT scan to clearly identify pain generators, once again not meeting the ODG Guidelines. While this patient may well be a candidate for a central canal and neural foraminal decompression on the basis of her degenerative disc disease resulting in spinal stenosis both centrally and neural foraminaly, the adjunct of the fusion is not supported in the literature and based on these medical records does not satisfy the ODG Guidelines. The treating physician has not explained why the ODG Guidelines should be set aside in this case. The previous adverse determination cannot be overturned based on the records submitted for this review. The reviewer finds that medical necessity does not exist for 2 Day Inpatient LOS with lumbar surgery with examination under anesthesia, Lumbar Laminectomy, Discectomy, Arthrodesis with Cages, Posterior Instrumentation, and Implantation of a Bone Growth Stimulator (EBI) at L4-5-S1.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

- ACOEM-AMERICA 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)