

## Notice of Independent Review Decision

**DATE OF REVIEW:** 3/23/2009  
**IRO CASE #:**

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

Lumbar Laminectomy with Fusion and Instrumentation L4-5 and L5-S1 with 1 day LOS

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer attended before graduating from. This reviewer did their residency in neurosurgery and a fellowship in pediatric neurosurgery at the. This reviewer has had numerous publications and is an active member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. This reviewer is a licensed medical doctor in five states.

**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)

Lumbar Laminectomy with Fusion and Instrumentation L4-5 and L5-S1 with 1 day LOS Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Carrier submission dated 3/6/2009
2. Notification of determination by MD dated 1/21/2009
3. Clinical note by MD dated 2/9/2009
4. Independent medical exam by MD dated 11/18/2008
5. Clinical note by MD dated 4/16/2008
6. Peer review by MD dated 2/7/2008
7. Independent medical exam by MD dated 11/28/2006
8. Emergency physician record dated XX/xx/xx
9. Physician orders dated xx/xx/xx
10. Admission agreement dated xx/xx/xx
11. Consent to drug dated xx/xx/xx
12. Management charge sheet dated unknown
13. Adult admission assessment dated xx/xx/xx
14. Trauma assessment dated xx/xx/xx
15. Clinical note dated xx/xx/xx
16. Clinical note dated unknown
17. Certificate to returns dated 5/9/2005
18. Clinical note dated xx/xx/xx
19. Discharge summary by MD dated 5/1/2005
20. History and physical examination by MD dated 5/1/2005
21. Emergency physician record dated unknown
22. Physician orders dated 5/1/2005
23. Progress record dated 5/1/2005
24. Physician orders dated 5/1/2005
25. Admission agreement dated 5/1/2005
26. Operative report by MD dated 5/1/2005
27. Lumbar spine x-ray by MD dated 5/1/2005
28. Radiology report by MD dated 5/1/2005
29. Radiology report by MD dated 5/1/2005

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30. Radiology report by MD dated 5/1/2005
31. Radiology report by MD dated 5/1/2005
32. Radiology report by MD dated 5/1/2005
33. Radiology report by MD dated 5/1/2005
34. Radiology report by MD dated 5/1/2005
35. Radiology report by MD dated 5/1/2005
36. Radiology report by MD dated 5/1/2005
37. Management charge sheet dated 5/1/2005
38. Clinical note dated 5/1/2005
39. Interdisciplinary progress notes dated 5/1/2005
40. Adult admission assessment dated 5/1/2005
41. Adult Trauma assessment dated 5/1/2005
42. Progress notes dated 5/1/2005
43. Nursing admission assessment dated 5/1/2005
44. Adult admission assessment dated 5/1/2005
45. Medication administration dated 5/1/2005
46. Plan of care dated 5/1/2005
47. Clinical note dated 5/1/2005
48. Care prevention dated 5/1/2005
49. Graphic chart dated 5/1/2005
50. Adult admission assessment dated 5/1/2005
51. Operative report by MD dated 5/1/2005
52. Emergency physician record dated 5/3/2005
53. Physician orders dated 5/3/2005 to 5/14/2005
54. Management charge sheet dated 5/3/2005 & 5/14/2005
55. Adult admission assessment dated 5/3/2005 to 5/14/2005
56. Clinical note dated 5/3/2005 & 5/4/2005
57. Emergency physician record dated 5/2/2005 to 5/14/2005
58. Pre-certification form dated 5/6/2005
59. Radiology report MD dated 5/6/2005
60. Preliminary report by MD dated 5/9/2005
61. Adult trauma assessment dated 5/14/2005
62. Clinical note dated unknown
63. Clinical note dated 5/19/2005
64. Discharge summary by PT dated 5/24/2005 to 6/22/2005
65. Physical therapy order dated 5/19/2005
66. Physical therapy evaluation dated 5/24/2005
67. Physical therapy progress notes dated 5/24/2005 to 6/24/2005
68. Flow sheet dated 5/31/2005
69. Clinical note dated 11/8/2005
70. Clinical note dated 5/19/2005 & 6/2/2005
71. Operative report by MD dated 6/11/2005
72. Outpatient orders dated 6/8/2005
73. Operative report by MD dated 6/10/2005
74. Verification checklist dated 6/10/2005
75. Pain clinic record dated 6/10/2005
76. Home instructions dated 6/10/2005
77. Outpatient orders dated 6/7/2005 to 6/27/2005
78. Prescription note dated 5/26/2005 & 6/30/2005
79. Radiology report by MD dated 6/13/2005
80. Radiology report by MD dated 6/13/2005
81. Clinical note dated 5/19/2005 & 6/30/2005
82. Operative report by MD dated 7/1/2005
83. Pain clinic record dated 7/1/2005
84. Home instructions dated 7/1/2005
85. Operative report by MD dated 7/1/2005
86. Clinical note dated 6/30/2005 & 7/14/2005
87. Operative report by MD dated 8/16/2005
88. Operative report by MD dated 8/16/2005
89. Discharge summary by MD dated 8/17/2005
90. History and physical examination by MD dated 8/16/2005

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91. Progress record dated 8/16/2005 & 8/17/2005
92. Pre-procedure dated 7/22/2005
93. Physician's orders dated 8/16/2005 & 8/17/2005
94. Operative report by MD dated 8/16/2005
95. New organization dated 3/3/2009
96. Clinical note dated 5/19/2005 to 1/29/2009 multiple dates
97. Operative report by MD, dated 9/12/2008
98. Radiology report by MD, dated 7/10/2007
99. Discharge summary by MD, dated 1/17/2007
100. Radiology report by MD, dated 9/28/2006
101. Operative report by MD, dated 6/6/2006 and 8/18/2006
102. Radiology report by MD, dated 6/6/2006
103. Radiology report by MD, dated 12/13/2005
104. Discharge summary by MD, dated 8/16/2005
105. Operative report by MD, dated 7/1/2005
106. Radiology report by MD, dated 6/13/2005
107. Operative report by MD, dated 6/10/2005
108. Pre procedure checklist dated 8/16/2005
109. Verification checklist dated unknown,
110. Radiology report by MD, dated 8/16/2005
111. Final chart dated 8/17/2005
112. Interdisciplinary plan of care dated 8/16/2005
113. Interdisciplinary progress note dated 8/16/2005 and 8/17/2005
114. Clinical note dated 8/17/2005
115. Nursing discharge transfer dated 8/17/2005
116. Follow up dated 8/17/2005
117. Adult admission assessment dated 8/16/2005
118. Treatment plan of care dated unknown,
119. Initial assessment dated unknown,
120. Family teaching flow sheet dated 8/16/2005
121. Radiology report by MD, dated 8/16/2005
122. Pre operative dated 8/16/2005
123. Treatment record dated unknown,
124. Exercise therapy dated 9/30/2005 to 10/25/2005 multiple dates
125. Clinical note dated 9/30/2005
126. Clinical note dated 9/16/2005
127. Initial evaluation dated 9/30/2005
128. Physical therapy request dated 9/20/2005
129. Clinical note dated 10/17/2005
130. Clinical note dated 6/30/2005 to 12/28/2006 multiple dates
131. Emergency care record dated 10/19/2005
132. Discharge instruction dated 10/20/2005
133. Physician record dated unknown,
134. Physician order dated unknown,
135. Adult admission assessment dated 11/10/2005
136. Discharge instruction dated 11/11/2005
137. Clinical note dated
138. Physician therapy notes dated 11/17/2005 to 12/6/2005
139. Flow sheet dated 11/22/2005 and 11/29/2005
140. Outpatient order dated 12/8/2005
141. Radiology report by MD, dated 12/13/2005
142. Clinical note dated 1/31/2006
143. Clinical note dated 1/31/2006
144. Patient information dated 2/20/2006
145. Clinical note by MD, dated 2/27/2006
146. Report of medical evaluation dated 2/20/2006
147. Clinical note dated 2/20/2006
148. Medical evaluation by MD, dated 2/23/2006 and 3/9/2006
149. Clinical interview dated 4/11/2006
150. Clinical note dated 5/1/2006 and 5/2/2006
151. Daily check list dated 5/1/2006 to 5/5/2006 multiple dates

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152. Daily progress note dated 5/1/2006 to 5/5/2006 multiple dates
153. Exercise dated 5/1/2006 to 5/5/2006 multiple dates
154. Daily symptoms scale dated 5/2/2006
155. Productivity index dated 5/1/2006 to 5/5/2006 multiple dates
156. Daily activities dated 5/1/2006 to 5/5/2006 multiple dates
157. Daily medication sheet dated 5/1/2006 to 5/5/2006 multiple dates
158. Progress notes dated 6/6/2006
159. Outpatient order dated 6/6/2006
160. Physician order dated 6/6/2006
161. Operative report by MD, dated 6/6/2006
162. Radiology report by MD, dated 6/6/2006
163. Clinical note by MD, dated 7/17/2006
164. Clinical note dated unknown,
165. Clinical note dated 7/10/2006
166. Report of medical evaluation dated 7/10/2006
167. Progress note by MD, dated 6/22/2006 and 9/15/2006
168. Clinical note by MD, dated 7/20/2006 and 8/17/2006
169. Outpatient order dated 8/9/2006
170. Operative report by MD, dated 8/18/2006
171. Home instruction dated 8/18/2006
172. Operative report by MD, dated 8/18/2006
173. Contrast protocol dated 9/28/2006
174. Outpatient order dated 9/28/2006
175. Radiology report by MD, dated 9/28/2006
176. Interdisciplinary progress note dated 9/28/2006
177. Radiology report by MD, dated 9/28/2006
178. Work status report dated 11/28/2006
179. Independent medical exam by MD, dated 11/28/2006
180. Operative report by MD, dated 1/16/2007
181. Operative report by MD, dated 1/16/2007
182. Pre operative dated 2/8/2007
183. History and physical examination by MD, dated 1/16/2007
184. Progress note dated 1/16/2007 and 1/17/2007
185. Pre procedure dated 1/16/2007
186. Physician order dated 1/16/2007
187. Physician order dated 1/16/2007
188. Physician order dated 1/17/2007
189. Operative report by MD, dated 1/16/2007
190. Nursing flow sheet dated 1/16/2007 and 1/17/2007
191. Interdisciplinary progress note dated 1/16/2007 and 1/17/2006
192. Adult admission assessment dated 1/16/2007
193. Nursing admission assessment dated 1/29/2007
194. Treatment plan of care dated 1/29/2007
195. Discharge instruction dated 1/17/2007
196. Progress note by MD, dated 2/5/2007 to 6/7/2007 multiple dates
197. Clinical note by MD, dated 4/11/2007 to 1/8/2009 multiple dates
198. Clinical note by MD, dated 4/23/2007
199. Report of medical evaluation dated 4/16/2007
200. Clinical note dated 4/16/2007
201. Clinical note dated 2/19/2007 to 1/29/2009 multiple dates
202. Radiology report by MD, dated 7/10/2007
203. Clinical note by MD, dated 12/6/2007
204. Clinical note dated 12/3/2007
205. Report of medical evaluation dated 12/3/2007
206. Radiology report by MD, dated 9/12/2008
207. Operative report by MD, dated 9/12/2008
208. Radiology report dated 9/12/2008
209. Radiology report by MD, dated 9/12/2008
210. Independent medical exam by MD, dated 11/18/2008
211. Pre procedure checklist dated 8/16/2005
212. Verification checklist dated unknown,

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213. Radiology report by MD, dated 8/16/2005
214. Final chart dated 8/17/2005
215. Interdisciplinary plan of care dated 8/16/2005
216. Interdisciplinary progress note dated 8/16/2005 and 8/17/2005
217. Clinical note dated 8/17/2005
218. Nursing discharge transfer dated 8/17/2005
219. Follow up dated 8/17/2005
220. Adult admission assessment dated 8/16/2005
221. Treatment plan of care dated unknown,
222. Initial assessment dated unknown,
223. Family teaching flow sheet dated 8/16/2005
224. Radiology report by MD, dated 8/16/2005
225. Pre operative dated 8/16/2005
226. Treatment record dated unknown,
227. Exercise therapy dated 9/30/2005 to 10/25/2005 multiple dates
228. Clinical note dated 9/30/2005
229. Clinical note dated 9/16/2005
230. Initial evaluation dated 9/30/2005
231. Physical therapy request dated 9/20/2005
232. Clinical note dated 10/17/2005
233. Clinical note dated 6/30/2005 to 12/28/2006 multiple dates
234. Emergency care record dated 10/19/2005
235. Discharge instruction dated 10/20/2005
236. Physician record dated unknown,
237. Physician order dated unknown,
238. Adult admission assessment dated 11/10/2005
239. Discharge instruction dated 11/11/2005
240. Clinical note dated
241. Physician therapy notes dated 11/17/2005 to 12/6/2005
242. Flow sheet dated 11/22/2005 and 11/29/2005
243. Outpatient order dated 12/8/2005
244. Radiology report by MD, dated 12/13/2005
245. Clinical note dated 1/31/2006
246. Clinical note dated 1/31/2006
247. Patient information dated 2/20/2006
248. Clinical note by MD, dated 2/27/2006
249. Report of medical evaluation dated 2/20/2006
250. Clinical note dated 2/20/2006
251. Medical evaluation by MD, dated 2/23/2006 and 3/9/2006
252. Clinical interview by dated 4/11/2006
253. Clinical note dated 5/1/2006 and 5/2/2006
254. Daily check list dated 5/1/2006 to 5/5/2006 multiple dates
255. Daily progress note dated 5/1/2006 to 5/5/2006 multiple dates
256. Exercise dated 5/1/2006 to 5/5/2006 multiple dates
257. Daily symptoms scale dated 5/2/2006
258. Productivity index dated 5/1/2006 to 5/5/2006 multiple dates
259. Daily activities dated 5/1/2006 to 5/5/2006 multiple dates
260. Daily medication sheet dated 5/1/2006 to 5/5/2006 multiple dates
261. Progress notes dated 6/6/2006
262. Outpatient order dated 6/6/2006
263. Physician order dated 6/6/2006
264. Operative report by MD, dated 6/6/2006
265. Radiology report by MD, dated 6/6/2006
266. Clinical note by MD, dated 7/17/2006
267. Clinical note dated unknown,
268. Clinical note dated 7/10/2006
269. Report of medical evaluation dated 7/10/2006
270. Progress note by MD, dated 6/22/2006 and 9/15/2006
271. Clinical note by MD, dated 7/20/2006 and 8/17/2006
272. Outpatient order dated 8/9/2006
273. Operative report by MD, dated 8/18/2006

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274. Home instruction dated 8/18/2006
275. Operative report by MD, dated 8/18/2006
276. Contrast protocol dated 9/28/2006
277. Outpatient order dated 9/28/2006
278. Radiology report by MD, dated 9/28/2006
279. Interdisciplinary progress note dated 9/28/2006
280. Radiology report by MD, dated 9/28/2006
281. Work status report dated 11/28/2006
282. Independent medical exam by MD, dated 11/28/2006
283. Operative report by MD, dated 1/16/2007
284. Operative report by MD, dated 1/16/2007
285. Pre operative dated 2/8/2007
286. History and physical examination by MD, dated 1/16/2007
287. Progress note dated 1/16/2007 and 1/17/2007
288. Pre procedure dated 1/16/2007
289. Physician order dated 1/16/2007
290. Physician order dated 1/16/2007
291. Physician order dated 1/17/2007
292. Operative report by MD, dated 1/16/2007
293. Nursing flow sheet dated 1/16/2007 and 1/17/2007
294. Interdisciplinary progress note dated 1/16/2007 and 1/17/2006
295. Adult admission assessment dated 1/16/2007
296. Nursing admission assessment dated 1/29/2007
297. Treatment plan of care dated 1/29/2007
298. Discharge instruction dated 1/17/2007
299. Progress note by MD, dated 2/5/2007 to 6/7/2007 multiple dates
300. Clinical note by MD, dated 4/11/2007 to 1/8/2009 multiple dates
301. Clinical note by MD, dated 4/23/2007
302. Report of medical evaluation dated 4/16/2007
303. Clinical note dated 4/16/2007
304. Clinical note dated 2/19/2007 to 1/29/2009 multiple dates
305. Radiology report by MD, dated 7/10/2007
306. Clinical note by MD, dated 12/6/2007
307. Clinical note dated 12/3/2007
308. Report of medical evaluation dated 12/3/2007
309. Radiology report by MD, dated 9/12/2008
310. Operative report by MD, dated 9/12/2008
311. Radiology report dated 9/12/2008
312. Radiology report by MD, dated 9/12/2008
313. Independent medical exam by MD, dated 11/18/2008
314. Official Disability Guidelines (ODG)

#### **INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a male who presented with low back pain from an injury dated xx/xx/xx, when he fell in a ditch and landed on a pipe. He is status post L4-L5 left microdiscectomy on 08/16/2005. He is status post L5-S1 laminectomy/discectomy 01/16/2007. He complains of low back pain with bilateral leg pain, left greater than right. He has been diagnosed with degenerative disc disease and spondylosis from L3 to L5-S1. His neurological evaluation reveals weakness in plantar and dorsiflexion bilaterally, left greater than right. A lumbar myelogram and CT 09/12/2008 noted severe bilateral foraminal stenosis at L4-L5. At L3-L4 there is a broad-based disc bulge with prominent bilateral neuroforaminal narrowing, severe on the left. There is a disc bulge at L5-S1 with moderate bilateral foraminal stenosis, left slightly greater than right. He is on long-term narcotics. He did get a psychological evaluation 04/11/2006. His provider recommended that he undergo a lumbar laminectomy with fusion and instrumentation at L4-L5 and L5-S1 with a 1 day inpatient stay.

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

The surgery is not medically necessary based on the documentation reviewed. Firstly, the Occupational and Disability Guidelines (ODG) recommend a preoperative psychological evaluation prior to performance of a lumbar fusion. The injured worker had a psychological evaluation, but nearly three years ago, and no mention was made regarding his suitability for surgery.

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Secondly, according to the ODG, all pain generators should be identified and treated. In this case, it is unclear that the only pain generators are the L4-L5 and L5-S1 levels. There are degenerative changes, as well, at L3-L4, with severe left neuroforaminal narrowing. The injured worker has left-leg symptoms, predominantly. An EMG might be useful, in this regard. Therefore, for reasons stated above, the lumbar fusion at L4-L5 and L5-S1 is not medically necessary and 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)