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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar diskectomy and decompression with TLIF at L2-L3 and L3-L4 with spine system, pedicle screws, bone PLF, allograft, EBS, NMS, In and LSO brace

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr. , 12/24/08
Peer review, Dr. , 01/29/09
ODG Guidelines and Treatment Guidelines
FCE, Dr. , 05/10/07
IME, Dr. , 09/09/08
Lumbar MRI, 10/16/08
Office note, Dr. , 01/28/09, 12/1/08
Letter to , Dr. , 12/13/08, 01/22/09
Fax for reconsideration, 01/23/09
Fax cover sheet, 12/22/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old male who injured his back on xx/xx/xx while performing his duties as a . The injury occurred when he slipped and fell holding a 35 pound hydraulic jack in one hand. The claimant had on 01/27/04 a right microdiscectomy at L3-4 with initial improvement of leg pain. A functional capacity exam was performed on 05/10/07 for problems of middle to low back pain, neck pain and inability to walk. It was noted the claimant had a history in 2006 of a stroke, a blocked carotid artery blocked with surgery. The impression was that the claimant was only capable of extremely sedentary work, and was in poor neurological and cardiovascular health. He was found not to be at medical maximum improvement. Dr. performed an independent medical exam on 09/09/08 and documented that he had examined

the claimant 16 months earlier and nothing had changed. The leg pain had worsened radiating laterally into the hip, up into the spine and stopped at the anterior knee. A note of a 08/06 lumbar MRI report stated that at L3-4 there was a paracentral disk protrusion extending into the right neural foramina compromising the right lateral recess.

There was mild disk desiccation and a L4-5 central bulge with some degeneration, and also some degeneration at L5/S1. Dr. felt an x-ray or possibly an MRI of the hip was needed to rule out advance degenerative changes, if there was no pathology then the problem would be clearly lumbar. The doctor stated the claimant could not work.

A 10/16/08 lumbar MRI revealed minor osteoarthritis at L2-3, a small central broad based disc bulge at L3-4 with stenosis at the right lateral recess with significant osteoarthritis of the facet joints, a small broad based disc bulge at L4-5 with bilateral joint space effusions and significant spinal or foraminal stenosis.

Dr. examined the patient on 12/1/08. Low back pain radiated down into the right buttock, down the anterior thigh, the pain was constant, and there was difficulty sleeping. At that time a discectomy, decompression and transforaminal interbody fusion with fixation at L2-3-4 was requested. On a 01/28/09 office exam, a right hip x-ray was interpreted as a normal study. The doctor again recommended the surgery he had previously requested.

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

The requested lumbar discectomy and decompression L2-L3 and L3-L4 with a spine system, pedicle screws, and allograft is not medically necessary based on review of this medical record.

The claimant has a lumbar MRI documenting some degenerative disc disease L3-L4 and L4-L5 but there is no documentation of structural instability, infection, recurrent disc herniation, or reason these specific levels were chosen for surgery. While it appears the claimant has had a previous L3-L4 disc herniation surgery, there is no documentation in the medical records of instability or other specific abnormality at that level. ODG guidelines document the use of lumbar spinal fusion in patients who have structural instability or large recurrent disc herniation at the same level, who have failed conservative care, all pain generators have been identified, and who have a psychosocial screen. In this case, there is no evidence of structural instability or large recurrent disc herniation, no evidence that all pain generators have been identified, and no evidence that a psychosocial screen has been performed. Therefore, the requested surgical intervention is not medically necessary.

There is no medical necessity for EBS stimulator since there is no medical necessity for fusion surgery.

There is no medical necessity for neuromuscular stimulator as there is no documentation in the orthopedic literature that a neuromuscular stimulator improves the patient's function or gets them back to more normal activities on a faster basis after surgery. Plus in this case, there is no medical indication for the surgery so there is no medical indication for postoperative treatment.

There is no medical indication for an LSO brace since there is no indication for surgery.

The reviewer finds that medical necessity does not exist for Lumbar discectomy and decompression with TLIF at L2-L3 and L3-L4 with spine system, pedicle screws, bone PLF, allograft, EBS, NMS, In and LSO brace.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)