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An Independent Review Organization
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DATE OF REVIEW:

May/08/2009

DATE OF AMENDED REVIEW: MAY 27, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LOS 5 TLIF L4-5 PSF L4, L5, S1, Exploration of Fusion, Removal of Hardware, Neuroplasty of nerve root and dura, spinal monitoring 22612, 22614 times two, 22630, 22840, 22851, 22830, 22852, 64714, 64722, 20930, 20937, 95920 (SC monitoring), 95926 (SSEP).

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

M.D., board certified in Orthopedic Surgery

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

Determination Letters, 4/7/09, 4/15/09

Lumbar Discogram, 1/4/02

Operative Report, 4/24/02

Operative Report, 7/21/03

Lumbar Myelogram and CT, 4/7/08

MD, 9/10/07, 11/5/07, 3/31/08, 1/5/09, 3/2/09

ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker, who injured his back in xx-xx-xx and subsequently underwent a previous L5/S1 anterior/posterior fusion with femoral ring in the anterior area and instrumentation posteriorly. He has also undergone a fusion at C5/C6. There was a discogram prior to the surgery that demonstrated that the L4/L5 disc in 2002 was normal. He has had lumbar flexion/extension films on 09/17/07, which noted a well-healed fusion at L5/S1. There is no mention of instability. A lumbar myelogram on 04/07/08 showed a solid fusion at L5/S1, no motion at L5/S1 was specifically indicated, and there was no mention of any abnormal motion at L4/L5. It was noted that there was some mild retrolisthesis of L4 on L5 with extension. Hence, this level was evaluated by the radiologist for instability. The patient did undergo a series of epidural steroid injections and therapy without help. The treating surgeon notes there is an L4/L5 instability with a 25-degree arc of motion at L4/L5, though this was not mentioned by the radiologist, even though the radiologist specifically documented findings the instability at L5/S1 and what was visible at L4/L5. Psychological

evaluation noted the patient was illiterate and borderline mentally retarded, but no contraindication for surgery. The patient has not undergone any pain procedures other than epidural steroid injections with a few to documenting the pain generators.

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

The medical records do not, in fact, document the 25-degree arc of instability other than for the note of Dr.. At L4/L5 a 20-degree arc of motion would be totally normal. Records show there is potentially a borderline degenerative instability. There is lack of significant disc abnormality on the myelogram and failure of the epidural steroid injections to give him even temporary relief. Investigations to determine whether the L4/L5 disc is the pain generator have not occurred. This man has not had repeat discography with the view to determine whether this borderline instability is indeed his pain generator. The pain generator has not been clearly identified as required by the ODG Guidelines. The instability is borderline. The disc itself on the myelogram is essentially normal. It is for all of these reasons that the reviewer finds that medical necessity does not exist for LOS 5 TLIF L4-5 PSF L4, L5, S1, Exploration of Fusion, Removal of Hardware, Neuroplasty of nerve root and dura, spinal monitoring 22612, 22614 times two, 22630, 22840, 22851, 22830, 22852, 64714, 64722, 20930, 20937, 95920 (SC monitoring), 95926 (SSEP).

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)