

SENT VIA EMAIL OR FAX ON
Sep/09/2009

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

360 fusion L5/S1 with 2 day inpatient stay

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

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

OD Guidelines

MRI lumbar spine, 12/14/06

Consult, Dr., 03/27/07

Office notes, Dr., 04/19/07, 05/03/07

Office notes, Dr., 07/05/07, 10/04/07, 11/08/07

X-ray lumbar, 10/04/07

MRI lumbar, 10/11/07

CT lumbar, 12/11/07

Office notes, Dr., 12/13/07, 06/12/08, 08/26/08

Office notes, Dr., 10/28/08, 11/25/08, 12/23/08, 01/27/09, 02/11/09, 03/24/09, 05/05/09,

06/01/09, 07/01/09, 07/20/09

X-ray lumbar, 10/28/08

MRI lumbar, 11/03/08

Procedure, 12/11/08

Peer review, 12/30/08

DEXA bone density, 01/12/09

Office note, , PhD, 02/09/09

Discogram, 04/28/09

Peer review, Dr., 07/24/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx-year-old female injured on xx/xx/xx when she was rolling some doors and felt severe low back pain. She had an L5- S1 discectomy in 1989. A 12/14/06 MRI of the lumbar spine noted that surgery was suspected at L5-S1 with narrowing of the disc space and thinning of the lamina on the left; enhancing scar on the left; superior spurring and facet joint hypertrophy. There was no compromise of the foramina or the thecal sac. There was L4-5 mild desiccation and a bulge that abutted the thecal sac causing mild effacement. The claimant treated for low back and bilateral leg pain with epidural steroid injections and medication.

A 10/11/07 MRI of the lumbar spine showed prominent disc space narrowing and probable post-op changes at L5- S1. There was some enhancing scar toward the left and thinning of the lamina and facet joint spurring prominently at L5- S1 on the left. At L4-5 was an annular bulge and slight desiccation with mild facet joint spurring. A 12/11/07 CT showed moderate to severe loss of disc space height at L5- S1 with mild endplate osteophytes, mild to moderate left and mild right facet joint arthropathy and mild bony foraminal narrowing bilaterally. There was suggestion of a mild bulge at L4-5 with minimal facet arthropathy at this level bilaterally.

The claimant treated with Dr. in 2008 for low back and bilateral leg pain. The examination documented normal strength, sensation and reflexes. Straight leg raise caused back and buttock pain. Treatment included facet injections. 10/28/08 x-rays of the lumbar showed no instability on flexion extension but there was moderate to severe narrowing at L5- S1. An 11/08 MRI showed degenerative facet changes and post laminectomy changes on the left at L5- S1. The diagnoses included low back pain with right leg pain, status post lumbar laminectomy 1989 with probable facet syndrome at L4-5 and L5- S1.

In early 2009, a discogram was recommended for ongoing pain and possible surgery. On 02/09/09 Dr. / PhD, felt the claimant was clear to proceed with a discogram and/or surgery.

On 03/24/09, Dr. reported the claimant had left leg pain and had been seen in the emergency department and treated with oral steroid medication that was of no benefit now having pain on left leg down into ankle. On examination, sitting root testing on the left produced left leg pain and on the right produced posterior thigh pain. A discogram was again recommended.

The lumbar discogram was done on 04/28/09. There was posterior fissuring and leaking at L5- S1 with pain. At L4-5, the claimant reported mild pain and there was no pain at L3-4.

Back and bilateral leg pain persisted and L4-5 and L5-S1 fusion was recommended. This was denied. The physician has now recommended fusion at L5-S1 only.

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

The requested L5-S1 fusion with 2-day length of stay is not medically necessary based on review of this medical record.

This claimant is a xx-year-old woman who has had ongoing pain since an injury in xxxx. She had a previous L5-S1 lumbar disc operation years ago and following her most recent injury underwent diagnostic testing documenting degenerative disc disease L5-S1. She has had a discogram documenting concordant pain at L5-S1 but has not undergone flexion/extension films describing structural instability and does not appear to have a disc herniation or progressive neurologic disc function.

ODG guidelines document the use of lumbar fusion in patients who have a neural arch defect or segmental instability. These do not appear to be present in this case. The use of discogram for preoperative planning to determine who may benefit from lumbar spine fusion has not been found to be a good correlating measure.

Therefore, in light of the lack of evidence of structural instability or the lack of recurrent disc herniation necessitating decompression, then the requested surgical intervention is not medically necessary.

Official Disability Guidelines 2009 Low Back Fusion
Milliman Care Guidelines 13th Edition Inpatient and Surgical Care

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)