

**I-Resolutions Inc.**  
**An Independent Review Organization**  
8836 Colberg Dr.  
Austin, TX 78749  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**

Aug/09/2010

**IRO CASE #:**

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

Inpatient Surgery for Re-exploration complete removal of facet, and decompression of nerve root L5 and S1 on the left, decompression of the L4 nerve root and removal of disc at L4-5 and posterior lumbar interbody fusion at L4-5 and L5-S1 followed by stabilization with pedicle screws and rod

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

MD, Board Certified Orthopedic Surgeon and Board Certified 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**

OD Guidelines

Denial notices, 6/29/10, 7/12/10

M.D. 6/28/10

attorney 6/22/10, 7/7/10

Metroplex 2/16/09

Radiological Association 1/29/10

D.O. 10/8/09, 12/17/09, 3/11/10

Rising 5/19/10

M.D. 6/25/10

7/21/09

1/23/09

9/28/09, 11/30/09

Pain Associates 12/2/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a worker who fell from a ladder directly onto his back, which caused of left-sided radicular complaints, according to the history. He also had a car accident, which apparently caused right-sided complaints. He had a remote history in 1983 of having a left-sided L5/S1 discectomy. He has had physical therapy. He apparently has had an L5 nerve root block on the left, although the results of this were not available in the records provided. He has had a myelogram with post CT scan which showed a small left partially calcified disc at L4/L5 which "may" encroach on the left L5 nerve root. It is noted that the L5 nerve root on the left may also be restricted. There is note that there may be some osteophytic spurring as well as scarring on the left at L5/S1 related to previous surgery. Diffuse spondylosis is also noted. Current request is for complete removal of the facet along with a two-level discectomy and fusion.

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

Based upon the medical records provided, there is no evidence of instability per ODG Guidelines. Within the records there is a notation stating that flexion/extension views were not requested. If there has been an attempt to identify the pain generators, it is not available in the medical record for this reviewer to review. As far as removal of the entire facet is concerned, there is no indication in the medical record why this would be necessary, and the surgeon involved does not explain why total facet removal is indeed indicated. The changes are relatively minor on the CT scan myelogram. Even if the facet was completely removed, this does not automatically indicate that the patient's spine will be destabilized. Furthermore, this patient has had one previous laminectomy, and one previous laminectomy does not meet ODG spinal fusion requirements. This patient most definitely does not meet the requirements in the ODG Guidelines, which are statutorily mandated. All pain generators have not been identified and treated. There is an absence of documentation of selective root blocks or other studies to determine pain generators. X-rays do not demonstrate spinal instability. Discography has not been performed. Pathology does appear to be limited to two levels, although there is spondylosis at adjacent levels. Psychological screening does not appear to be fully completed, although it is in part. As far as smoking is concerned, we do not know whether or not cessation of smoking or absence of smoking was indeed the situation in this patient's case. This patient does not meet ODG Guidelines and Treatment Guidelines criterion for fusion, in particularly the instability criterion and the failure to document all pain generators criterion. The reviewer finds that medical necessity does not exist at this time for Inpatient Surgery for Re-exploration complete removal of facet, and decompression of nerve root L5 and S1 on the left, decompression of the L4 nerve root and removal of disc at L4-5 and posterior lumbar interbody fusion at L4-5 and L5-S1 followed by stabilization with pedicle screws and rod.

**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)