US Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-5 Revision Laminectomy, Discectomy, Arthrodesis w/cages, posterior instrumentation: L5-S1, Removal posterior instrumentation with 2 Day Inpatient Hospital Stay

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified in Neurological Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
11/11/10, 11/3/10
M.D. 8/4/09 to 10/26/10
M.D. 10/12/10
Hospital 12/9/09
Pain Care, 11/21/08 to 10/25/10
Imaging 3/11/09, 7/7/10
D.C. 6/30/10
Pain Consultants 11/21/07 to 10/3/08
12/17/07 to 3/12/08
Neurology & Neurophysiology, P.A. 2/12/08
Radiology Associates 2/5/08
5/17/07 to 4/2/08
Diagnostic 1/3/07
MRI 7/11/08 to 9/8/08
6/9/08
Healthcare Systems 10/2/08 to 9/16/10
Healthcare 10/3/08 to 11/7/08
Spine & Orthopaedic Institute 10/16/08 to 11/17/08
Rehab Therapy Resources, Inc. 2/23/09
12/10/09
Physical Therapy & Wellness Center 2/24/10 to 7/30/10
Counseling Center 10/7/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx. She is status post L4-S1 fusion. She complains of bilateral leg pain, left greater than right. She has undergone nerve root blocks, pain management, and physical therapy. An EMG/NCV 10/12/2010 reveals a chronic L5 radiculopathy bilaterally. An MRI of the lumbar spine 07/07/2010 shows, at L4-L5 a diffuse disc bulge with mild encroachment of the left L5 nerve root. There is neuroforaminal narrowing on the left. No abnormalities are seen at L5-S1. Her neurological examination 10/26/2010 reveals a decreased knee jerk on the left, mild left extensor hallicus weakness, and left L5 parasthesias. The provider states that there is some loss of anterior column support at L4-L5 and ossification of the posterior longitudinal ligament, creating lateral recess stenosis. The provider is recommending L4-5 Revision Laminectomy, Discectomy, Arthrodesisw/cages, posterior instrumentation: L5-S1, removal posterior instrumentation with 2 Day IP Hospital Stay.

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

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The claimant has a failed fusion at L4-L5 with a herniated disc and objective clinical as well as radiographic evidence of a left L5 radiculopathy. It is, therefore, medically necessary to decompress and re-fuse this segment. It is also medically necessary, as L5-S1 looks completely healed, to remove the hardware at that level at the same time, to minimize the amount of potential hardware pain. According to the ODG, “Low Back” chapter, a lumbar fusion is indicated for “revision Surgery for failed previous operation(s) if significant functional gains are anticipated”. The claimant has a failed fusion at L4-L5 with evidence of a left L5 nerve root compression. There are functional gains anticipated from the proposed procedure. The reviewer finds that medical necessity does exist for L4-5 Revision Laminectomy, Discectomy, Arthrodesis w/cages, posterior instrumentation: L5-S1, Removal posterior instrumentation with 2 Day Inpatient Hospital Stay.

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

[X] 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)