

SENT VIA EMAIL OR FAX ON
Jan/15/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IP L5/S1 ALIF/PISF w/3day LOS

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, 09/18/09

Office notes, Dr., 10/09/09, 11/23/09

Operative Report, Dr., 11/09/09

Surgical Scheduling Form

Letter of denial, , 12/07/09, 12/17/09

Coding form, Dr., undated

PATIENT CLINICAL HISTORY SUMMARY

This female sustained a lifting injury to her low back on xx/xx/xx with persistent right sided low back pain and right lower extremity radicular symptoms and a diagnosis of lumbar sprain/strain, right L5-S1 herniated nucleus pulposus and right S1 radiculopathy. A lumbar MRI dated 09/18/09 was reviewed by Dr. to reveal a right posterolateral protrusion at L5-S1 with a small annular tear that slightly displaced the right S1 nerve root. The 10/09/09 exam revealed right paravertebral muscle spasms, tenderness to palpation, limited range of motion due to pain and a diminished right Achilles reflex. A lumbar epidural steroid injection performed on 11/09/09 provided 50 percent relief for a 2-day period of time with gradually worsening of her pain. The 11/23/09 exam now revealed an absent right Achilles reflex and a positive right nerve root stretch. Failed conservative care had included time, activity modifications, physical therapy, anti-inflammatories, muscle relaxers and analgesics with the claimant taken off work with on light duty available. Authorization was requested for an anterior lumbar interbody fusion with cage or allograft and instrumentation with an L5-S1 laminectomy and instrumented posterolateral fusion and possible iliac crest bone graft.

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

This would not appear to be a case of spondylolisthesis or spinal instability. Rather there appears to be a right-sided disc herniation at L5-S1. The radiologist has not documented any severe or progressive degenerative changes at that disc level. There is no documentation of a psychologic screening.

The records as presented would not satisfy the ODG Guidelines for a spinal fusion procedure

Care Guidelines® Inpatient and Surgical Care 13th Edition

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates: Low Back – Spinal Fusion

Spinal Fusion:

- Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction.
- Recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care.

Spinal Fusion:

Pre-Operative Surgical Indications Recommended: should include all of the following:

- 1) All pain generators are identified and treated; &
- 2) All physical medicine and manual therapy interventions are completed; &
- 3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography & MRI demonstrating disc pathology; &
- 4) Spine pathology limited to two levels; &
- 5) Psychosocial screen with confounding issues addressed.
- 6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis.

- Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion.
- Unilateral instrumentation used for the treatment of degenerative lumbar spondylolisthesis is as effective as bilateral instrumentation.
- Patients with degenerative spondylolisthesis and spinal stenosis who undergo standard decompressive laminectomy (with or without fusion) showed substantially greater improvement in pain and function than patients treated nonsurgically.
- For degenerative lumbar spondylolisthesis, spinal fusion may lead to a better clinical outcome than decompression alone.

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)