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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-3-4-5 lumbar laminectomy, discectomy; L5-S1 arthrodesis with cages; posterior instrumentation, reduction of spondylolisthesis; and 2 days inpatient stay

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

MD, Board Certified Neurosurgeon

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

ODG Indications for Surgery – Discectomy/laminectomy

Denial Letters, 8/19/10, 8/30/10

M.D., P.A. 6/22/10, 6/21/10

Associates 8/10/10

8/26/09, 12/2/08

Diagnostic Center 12/16/08

Health and Occupational 6/8/10

Medical Center 1/16/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female with a date of injury xx/xx/xx, when she was and her foot was caught, causing her to twist her leg. She complains of back pain and bilateral leg pain, right greater than left. She underwent left knee surgery on 01/16/2009. She has undergone physical therapy. On 06/22/2010 her neurological examination revealed a decreased ankle and knee jerk on the right. There is weakness of the gastrocnemius, ehl, and anterior tibialis on the right. An MRI of the lumbar spine 08/26/2009 shows at L2-L3: a 4mm disc bulge with flattening of the thecal sac without foraminal narrowing. At L3-L4 there is a disc herniation that flattens the thecal sac with mild bilateral foraminal narrowing. At L4-L5 there is a left subarticular disc herniation that flattens the thecal sac and compresses the L5 nerve root sleeve. At L5-S1 there is no focal disc herniation or foraminal encroachment.

In his note of 06/22/2010 the provider states that there is a 10mm spondylolisthesis at L5-S1 on plain films, although there are no reports provided for review. An EMG/NCV of the lower extremities 12/16/2008 showed an L5-S1 radiculopathy. A psychological screen 08/10/2010 showed a fair prognosis for the intended surgical procedure.

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

The proposed surgery to include L2-3-4-5 lumbar laminectomy, discectomy; L5-S1 arthrodesis with cages; posterior instrumentation, reduction of spondylolisthesis; and 2 days inpatient stay is not medically necessary. The provider states there is a spondylolisthesis at L5-S1, and therefore is requesting a fusion at this level. There is no independent radiological verification of this. Moreover, the only neural compression documented is at L4-L5, and this compression is seen to the left, whereas the claimant's greatest complaints are to the right. According to the ODG, "Low Back" chapter, Pre-Operative Surgical Indications: "All pain generators" should be... "identified and treated". In this case, it is not clear that the pain generator(s) have been adequately identified. The radiographic images do not correlate with the claimant's complaints, exam, or the surgical plan. Therefore, the surgery does not meet the ODG patient selection criteria for the procedure. The reviewer finds that medical necessity does not exist for L2-3-4-5 lumbar laminectomy, discectomy; L5-S1 arthrodesis with cages; posterior instrumentation, reduction of spondylolisthesis; and 2 days inpatient 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

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)