

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825**

Notice of Independent Review Decision

DATE OF REVIEW: MAY 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient 3 day stay for lumbar laminectomy L1-2 with fusion instrumentation L1-2 and back brace at Shannon Medical Center.

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

AMERICAN BOARD OF NEUROLOGICAL SURGERY

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

PATIENT CLINICAL HISTORY:

The patient's date of accident is xx/xx/xx. Amazingly, the records contain great amounts of information. There are a few duplications but no details, whatsoever, of the description of the initial accident or the subsequent surgery(s) until 2002. There is a brief mention that there was a second surgery in 1997. There are then detailed records from October 2002, that I am summarizing in this report. I see inconsistencies between right and left complaints and the basis of the disc herniation that may be simply an error of transposition. I also see inconsistencies as to the degree of severity of interpretation of CT scans/myelograms. I am puzzled by why no discectomy was performed at the L1-2 level, when it was operated on July 23, 2008. The studies at the time did not reveal too much abnormality on the disc, and very moderate ligamentous abnormalities. In my opinion, this was the reason the disc was not excised. This has come back to haunt the patient. In addition, if all x-rays have been interpreted to reveal solid fusions from L1 to S1, why the herniation at L1-2?

Nonetheless, it appears that there is radiological progression of disc abnormalities at the L1-2 level and, judging by Dr. notes, also worsening of the clinical presentation of the patient. Of course, it appears that this patient has rarely been free of pain or of surgery over the years since the 1990's.

The L1 and L2 nerve roots share the innervation of the iliopsoas muscle, which is mainly responsible for flexion of the hip, and I do not see this particular muscle group being tested. The surgeon indicates that weakness of patient's legs from quadriceps down is due to the lesion at L1-2; this could be possible as in a severe compression of the cauda equina, but local weakness of the iliopsoas should be also prominent.

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

Accepting that the patient's clinical symptomatology has gotten worse, that the radiological evidence demonstrates also worsening of the findings, and that the patient has had several epidural steroid injections and several months of experiencing symptoms without clinical improvement, it appears that a discectomy would be in order. Is this what the surgeon wants to accomplish? If this is the case, then surgery is justified. According to 2010 ODG Guidelines on page 639, the documentation presented fulfills the requirements for discectomy and laminectomy.

In addition, the surgeon is proposing also a fusion with instrumentation. Here again, referring to 2010 ODG Guidelines on page 660, specifically under (3) and (4), a fusion would be indicated. However, was this level not already fused posterolaterally in a previous surgery? The answer is yes. If so, the surgeon will have to justify why he wants to add instrumentation to the fusion he already has performed in this patient at this lumbar level. If justification is provided, I see no objection to the procedure. However, I do offer as an alternative that instead of instrumentation he uses PLIFs. However, this is up to the surgeon in terms of preference.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)