mcmc
managing care. managing claims.
88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

IRO REVIEWER REPORT TEMPLATE –WC

DATE OF REVIEW:
03/08/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Is the anterior lumbar interbody fusion (ALIF) L5-S1, posterior lumbar decompression and posterolateral fusion and pedicle screw instrumentation with three day length of stay medically necessary?

A 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

No, the anterior lumbar interbody fusion (ALIF) L5-S1, posterior lumbar decompression and posterolateral fusion and pedicle screw instrumentation with three day length of stay is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- Case Report dated
- Referral dated 02/27/07
- DWC-69: Report of Medical Evaluation with Date of Exam 07/14/05
- Letter dated 02/21/07 from RN
- Texas Department of Insurance: Notice to Case Assignment dated 02/16/07
- Texas Department of Insurance: Confirmation of Receipt of a Request For a Review dated 02/15/07 with attachments
- LHL009: Request For a Review By An Independent Review Organization dated 02/15/07
- Letter dated 01/17/07
- Letter dated 01/17/07 from LVN
- Letter dated 12/27/06 from LPN
- P.A.: Letters dated 12/18/06, 08/14/06 from M.D.

88 Black Falcon Avenue, Suite 353 Boston, MA 02210 (T) 800-227-1464 (F) 617-375-7777

- Lumbar spine radiographs dated 12/11/06, C.T. scan of the lumbar post myelogram dated 08/03/06, Myelogram of the lumbar spine dated 08/03/06, MRI lumbar spine dated 05/12/04
- M.D.: Office notes dated 12/04/06, 10/13/06
- Lumbar spine CT dated 11/02/06
- Operative Report dated 11/02/06 from M.D.
- Letter dated 07/19/05 from DC

PATIENT CLINICAL HISTORY [SUMMARY]:
The injured individual had an injury when he was struck in the back. He has had multiple imaging studies. Several have not demonstrated any disc herniation. He had physical therapy (PT) and epidural steroid injections (ESI). In 08/2006, the injured individual had no evidence of disc herniation, canal or foraminal stenosis at any level. On exam in 08/2006, he had decreased sensation in the foot and weakness in the great toe and anterior tibialis. On 12/04/2006, the injured individual was diagnosed with lumbago with radiculopathy and internal disc disruption. There was no evidence of instability on flexion-extension views.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The injured individual had no instability, disc herniation, significant central canal or foraminal stenosis. Therefore, the surgery is not medically necessary or indicated in this injured individual. There is no surgical pathology according to the imaging studies. Lumbar fusion in an injured individual without instability or obvious disc herniation has not been found to be an effective and successful treatment modality. It is not medically indicated.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
OKU Spine, ACOEM Chapter 12