

Notice of Independent Review Decision

DATE OF REVIEW: 11/26/2007
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior and posterior L4-5, L5-S1 fusion with right L5-S1 decompression

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from Rutgers Medical School, after completing his undergraduate degree at Rensselaer Polytechnic Institute. He completed his internship in General Surgery at Pennsylvania Hospital and his residency in Orthopedic Surgery at University of Miami School of Medicine, Jackson, where he served as chief resident. He has been in active practice since 1984. He is a member of American Academy of Orthopaedic Surgeons, American Medical Association, Pennsylvania Orthopedic Society, Eastern Orthopedic Society, and Pennsylvania Medical Society.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

Anterior and posterior L4-5, L5-S1 fusion with right L5-S1 decompression Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note by, dated 11/12/2007
2. IRO request form dated 11/12/2007
3. Independent review organization dated 9/18/2007
4. Clinical note dated 8/26/2007
5. Clinical note dated 9/10/2007
6. Case assignment by, dated 11/13/2007
7. Clinical note dated 11/26/2007
8. Clinical note by, dated 11/16/2007
9. Disability duration guideline dated 11/26/2007
10. Official Disability Guidelines (ODG)
11. Description note dated 11/26/2007
12. Clinical note dated 8/26/2007
13. Clinical note dated 9/10/2007

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a xx year old male who sustained an injury on xx/xx/xx. Minimal clinical notes were provided. This case is under review to determine if the previously denied request, anterior and posterior L4-5, L5-S1 fusion with right L5-S1 decompression, is medically necessary.

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

When one looks closely to the imaging data in this case, the MRI has not identified any clearly persistent neural compressive lesion. The discogram was remarkable for "partial concordant" pain at L4-5. Disc morphology as identified on the CT scan has not had great predictive value in determining surgical success.

There is still no mention of psychological screening in this case. The absence of clear cut foraminal narrowing or neural compression is worrisome. As suggested above, the disc morphology on CT scan in and of itself is not a surgical indication.

The medical information provided does not substantiate the proposed two level fusion with decompression. Therefore, the request is deemed not medically necessary and the previous denial is upheld.

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

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)