

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 1, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Surgery (LOS) – Lumbar Laminectomy with Fusion and Instrumentation L4-5 and Removal of Previous Instrumentation with One Day Length of Stay

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for Spinal Surgery (LOS) – Lumbar Laminectomy with Fusion and Instrumentation L4-5 and Removal of Previous Instrumentation with One Day Length of Stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/24/08, 10/13/08

ODG Guidelines and Treatment Guidelines

MD, 1/21/08, 2/11/08, 3/13/08, 9/15/08, 10/2/08, 3/12/07, 6/18/07, 10/4/07, 11/20/06, 5/18/06, 3/9/06, 2/9/06, 12/6/06, 12/28/06

Operative Report, 4/18/08, 2/22/08, 12/6/06, 3/21/06, 2/21/06

CT Lumbar Spine w/contrast, 2/22/08

Radiology Reports, 6/18/07, 3/12/07, 12/28/06

Discharge Summary, 12/7/06

History and Physical, 12/6/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who has previously undergone L5/S1 anterior interbody fusion with posterior instrumentation on 12/06/06. It is stated he had an excellent result from his surgery, yet more than a year later, he was back in the doctor's office complaining of back pain and radiculopathy in a similar manner as his previous complaints. There is an indication from the doctor requesting the surgery that there is a defect of some sort at L4/L5, although this is not borne out by any of the medical records provided to this reviewer. There is an indication there is some radiculopathy present. However, epidural steroid injections at the target level do not give him any relief, indicating perhaps the origin of the radiculopathy is not yet determined. There is no evidence of pain generator verification. This gentleman has not had discogram or other imaging studies. The medical records do not show clear-cut evidence of a radicular neurological defect.

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

Based upon the ODG Guidelines and the information provided to this reviewer, the L4/L5 disc has not been identified as this gentleman's pain generator. Instability has not been noted in the records, and there are no imaging studies available in the records reviewed that would support the assertion that the L4/L5 disc could be the source of the pain that the patient is experiencing. The reviewer finds that medical necessity does not exist for Spinal Surgery (LOS) – Lumbar Laminectomy with Fusion and Instrumentation L4-5 and Removal of Previous Instrumentation with One Day Length of Stay.

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)**