

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior and posterior lumbar discectomy and fusion at L2-3. 3 day inpatient stay.

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

MD, Board Certified Orthopedic Surgeon
Spine 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 anterior and posterior lumbar discectomy and fusion at L2-3 and 3 day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/11/08, 6/20/08

ODG Guidelines and Treatment Guidelines

, 1/5/06, 7/7/05

MD, 5/22/08, 6/18/07, 4/19/07, 10/29/07, 1/4/07, 12/5/06, 11/9/06, 6/5/06, 3/31/06, 3/3/06, 1/23/06, 1/2/06, 5/9/05, 3/17/05, 3/1/05, 2/1/05, 1/19/05

BHI, 10/29/07

MRI of Lumbar Spine, 10/18/04

MRI of Right Wrist, 12/8/04

Operative Reports, 11/16/05, 8/17/05

CAT Scan of Right Wrist, 10/18/04

Lumbar Spine, 2 views, 9/24/04
Therapy, 10/28/07, 12/5/06, 11/9/06
FCE, 5/12/05, 5/13/05
X-Ray Lumbar, 2/1/05
X-Ray Wrist, 2/1/05
, Light, Job Description
, 10/4/06
, MD, 1/17/06, 12/1/05, 10/6/05, 8/25/05
Dr. , MD, 12/16/04, 12/2/04, 11/18/04, 10/21/04, 10/14/04, 9/30/04

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old male who was injured while at work on xx/xx/xx. He has had treatment, which is indicative of conservative care. There is no evidence of any neuromuscular deficit. There is no evidence within the medical record of segmental instability meeting the ODG criteria. Dr. has repeatedly requested a discogram with post-discographic CT scan in order to determine whether the one abnormal disc, the L2/L3 disc on his lumbar MRI scan, is the pain generator. Interestingly, while there is no spondylolisthesis or other instability, there is evidence of degenerative osteophytosis at multiple levels on the MRI scan and disc bulging encroaching on the neural foramen along with apophyseal joint hypertrophy. Psychological evaluation does not reveal any significant contraindication to surgery. Due to the failure of the carrier to approve discogram, Dr. has determined to move forward without it.

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

This patient does not meet ODG Guidelines due to the absence of instability. He is xx years of age and has abnormal discs at L2/L3 as his predominant finding. Without further objective evidence of discogenic pain, especially in conjunction with the patient's age, it is impossible to isolate this particular disc as the pain generator. The reviewer finds that medical necessity does not exist for anterior and posterior lumbar discectomy and fusion at L2-3 and 3 day inpatient 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)