

U.S. Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Fusion L4-5 63056, 22630, 22840, 20936, 22851, 69990, 77003, LOS x 1 day

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

M.D., 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 Lumbar Fusion L4-5 63056, 22630, 22840, 20936, 22851, 69990, 77003, LOS x 1 day.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter, 5/15/08
ODG-TWC, Low Back – Lumbar & Thoracic
MRI of Lumbar Spine, 12/17/07
AP & Lateral Views of the Lumbar Spine, 12/17/07
MD, 11/28/07, 3/27/08, 2/20/08, 1/17/08
Myelogram Lumbar, 7/31/07
CT Lumbar Spine without Contrast, 7/31/07
MD, 8/27/07

Ph.D., 5/27/08

Brain & Spine, MD, 6/12/08, 5/6/08, 2/14/08, 2/7/08, 1/17/08

Letter to IRO, 6/11/08

Report of Medical Evaluation, 5/22/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx-year-old injured female has low back pain with bilateral lower extremity pain related to moving a heavy patient. She apparently was seen in xxxx , originally and was subsequently referred for low back pain referred to both lower extremities. A myelogram with post-myelogram CT scan revealed mild disc space narrowing, small anterior osteophytes, and a moderate left greater than right disc bulge. An MRI scan from Imaging reveals an L4/L5 4-mm to 5-mm protrusion but no indication of an annular tear, and a retrolisthesis of grade 1, L4/L5. There is no documentation of true instability or annular tears indicative of discogenic pain. There was no discogram available in the medical records reviewed.

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

There is an abnormal disc at L4/L5, but the reviewer is unable to determine from the medical records provided if it is or is not the pain generator in this patient. In a xx-year-old person there is at least a 30% to 50% chance of abnormalities on the MRI scan occurring in patients who have never had back pain. (The patient was xx at the time of the MRI scan.)

There has been no evaluation using provocative discography performed according to Spine Society protocol in this case. This disc may be this patient's pain generator, but it also may not be. Without some indication that it is such as a detailed neurological abnormality and/or definitive discography, the reviewer is unable to reverse the previous adverse determination and must adhere to the ODG guidelines, which do not support the proposed surgery. The reviewer finds that medical necessity does not exist for Lumbar Fusion L4-5 63056, 22630, 22840, 20936, 22851, 69990, 77003, LOS x 1 day.

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
- AHCP- 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)**