

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 6/13/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar fusion with 3 day inpatient stay

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended the University of Pittsburgh School of Medicine after completing his undergraduate degree at the University of Virginia. He completed an internship and residency at Pennsylvania State University. He has been actively practicing since 1990. He is a member of the American Academy of Orthopaedic Surgeons and the American Medical Association.

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)

Lumbar fusion with 3 day inpatient stay Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated 05/28/2008
2. Review organization dated unknown.
3. Denial information dated unknown.
4. Clinical note dated unknown.
5. Request form dated 05/15/2008
6. Notice of utilization review dated 05/02/2008
7. Clinical note dated 05/02/2008
8. Notice of utilization review dated 05/14/2008
9. Clinical note dated 05/14/2008
10. Reconsideration request by MD dated 05/08/2008
11. Appeal procedure dated unknown.
12. Reviews of case assignment dated 05/28/2008
13. Clinical note dated 05/29/2008
14. Review organization dated 05/28/2008
15. Clinical note dated unknown.
16. Request form dated 05/15/2008
17. Clinical note dated 04/28/2008
18. Clinical note dated 04/15/2008
19. Office visit note dated 04/15/2008
20. Chart note dated 09/20/2007 and 10/18/2007
21. Office visit note dated 08/31/2007
22. Initial office visit note dated 08/07/2007
23. MRI I spine w&wo con by MD dated 08/20/2007
24. Imaging report by MD dated 03/28/2008
25. Imaging report by MD dated 03/28/2008
26. Imaging report by MD dated 03/28/2008
27. Operative report by MD dated 05/03/2007

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28. Operative report by MD dated 7/25/2007
29. Spine lumbar wo contrast MRI by MD dated 02/01/2007
30. Spine lumbar wo contrast MRI by MD dated 02/01/2007
31. EMG consultation by MD dated 06/07/2007
32. Electromyographic examination by MD dated 06/07/2007
33. Electromyographic examination by MD dated 06/07/2007
34. Notice of utilization review findings dated 05/02/2008
35. Clinical note dated 05/02/2008
36. Clinical note dated 05/07/2008
37. Clinical note dated 04/15/2008
38. Office visit note dated 04/15/2008
39. Chart note dated 09/20/2007 and 10/16/2007
40. Office visit note dated 08/31/2007
41. Initial office visit note dated 08/07/2007
42. MRI l spine w&wo con by MD dated 08/20/2007
43. Imaging report by MD dated 03/28/2008
44. Imaging report by MD dated 03/28/2008
45. Imaging report by MD dated 03/28/2008
46. Operative report by MD dated 05/03/2007
47. Operative report by MD dated 07/25/2007
48. Radiology report by MD dated 02/01/2007
49. Radiology report by MD dated 02/01/2007
50. EMG consultation by MD dated 06/07/2007
51. Electromyographic examination by MD dated 06/07/2007
52. Electromyographic examination by MD dated 06/07/2007
53. Notice of utilization review dated 05/14/2008
54. Clinical note dated 05/14/2008
55. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The employee is a male who sustained an injury while at work. He has had low back and left leg pain since 11/10/2008. He was lifting a box when he felt a pull in his back. He rates the pain as an 8-9/10 in intensity and it is localized in the lumbosacral region. He has undergone treatment with bracing, stimulators, injections, and other conservative modalities. At this time, the request for lumbar fusion with 3 day inpatient stay is under review for medical necessity.

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

Based on the information available, the L5-S1 fusion is not recommended as medically necessary. There is certainly no evidence of instability. There is no documentation that psychosocial screening has been performed to address confounding issues. These issues would need to be clarified before recommendation of the proposed procedure. This is consistent with the recommendations of the Official Disability Guidelines. Therefore, 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
- 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)

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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)