

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of spinal surgery.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI lumbar spine, 02/14/05, 10/26/07

Discogram, 04/26/05

Chart note, Dr. 03/03/08

Fax authorization, 03/20/08

Psych evaluation, Dr., 04/04/08

Adverse Determination Letter, Dr. 04/17/08

Request for reconsideration, 04/30/08

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, (low back, lumbar fusion)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with a reported injury date of xx/xx/xx. He felt pain in his lower back and a cramp in his right leg as he passed a pallet in a bent position. A subsequent MRI on 02/14/05 showed multilevel disc pathology with disc protrusions at L3-4 and L4-5 and a report of a moderate right L5-S1 disc herniation. The initial MRI of 02/14/05 reported right lateral recess greater than left. A later discogram reported showed concordant pain at the L3-4 level with no pain at the L5-S1 level and a normal L4-5 disc. Later repeat MRI of the lumbar spine on 10/26/07 showed degenerative changes at L3-4, 4-5, and L5-S1. A central disc herniation was noted at L5-S1 with no evidence of neural impingement.

Subsequent treatment by Dr. indicated dermatomal numbness at the "entire right lower extremity from the proximal thigh to all five toes". The claimant was reported to have received therapy and work hardening as well as prior epidural steroid injections with minimal relief. Dr. noted a diagnosis of spondylosis from L3 through S1 and recommended a fusion from L3 through S1. The claimant underwent a psychological evaluation with no overt psychological issues.

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

The requested multilevel fusion cannot be recommended as medically necessary based on the information reviewed. The claimant does not have instability and does not clearly have discogenic pain according to the prior discogram. The claimant is noted to have diffuse numbness that does not correspond to a dermatomal pattern. The claimant's symptoms cannot be explained by the objective pathology noted on the MRI.

For all of these reasons, the proposed spinal surgery procedure cannot be justified as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, (low back, lumbar fusion)

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 KNOWLEDGBASE
- 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)