

I-Decisions Inc.

An Independent Review Organization

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DATE OF REVIEW: NOVEMBER 7, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient transforaminal lumbar interbody fusion (TLIF) at L2/L3, L3/L4, and L4/L5 with two-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 Inpatient transforaminal lumbar interbody fusion (TLIF) at L2/L3, L3/L4, and L4/L5 with two-day length of stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 9/5/08, 9/30/08
ODG Guidelines and Treatment Guidelines
MD, 8/28/08, 6/27/08, 9/25/08, 7/18/08
MRI of Lumbar Spine, 2/25/08
Dr., 7/15/08, 1/14/08, 5/18/08, 4/17/08, 3/14/08
Operative Report, 5/31/06
MD, 3/17/03
MRI, 11/20/02
MRI, 12/29/00

Independent Medical Examination, 1/29/08
9/11/08
SIE DXI Lumbar Limited, 12/13/99
MRI, 7/18/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a female who had a date of injury xx/xx/xx. She was involved in an auto accident. She underwent apparently two previous lumbar surgeries at the L5/S1 level with instrumental fusion on or about 12/03/01. Her MRI scans in December 2000 and November 2002 did not reveal any significant pathology at any other level above the previous fusion. She has a current MRI scan that shows a disc bulge at L2/L3, protrusion/herniation at L3/L4, and spondylolisthesis at L4/L5, grade 1. The L5/S1 level is fused, and there is evidence of arachnoiditis. Current request is for Inpatient transforaminal lumbar interbody fusion (TLIF) at L2/L3, L3/L4, and L4/L5 with two-day length of stay.

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

This patient does not appear to have any neurological deficits within the medical records. The complaints are of back pain. There is no evidence that the pain generator has been isolated. The general accepted medical treatment would not recommend a four-level fusion or even a three-level fusion, particularly in the Workers' Compensation population, as the outcomes are uniformly poor. This patient has not completed the necessary steps to even be considered for a spinal fusion under the ODG Guidelines:

1. One or all pain generators have been identified and treated. This has not been accomplished.
2. All medicine and manual therapy interventions have been completed. This appears to have been accomplished.
3. X-rays demonstrating spinal instability or CT scan myelogram or discography criteria. This has not been completely accomplished, as the instability requiring surgery has not been demonstrated, but the MRI scan has shown some pathology.
4. Spine pathology is limited to two levels. In this case multiple levels are involved, and so this criteria is not met.
5. Psychological screening with compounding issues addressed. This has not been accomplished.

Based upon the ODG Guidelines, this patient has not had her pain generator identified, has not had any psychological issues addressed, and has more than the two levels. There is no neurological deficit, and no spinal stenosis resulting in radiculopathy or myelopathy. The reviewer finds that medical necessity does not exist for Inpatient transforaminal lumbar interbody fusion (TLIF) at L2/L3, L3/L4, and L4/L5 with two-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)