

SENT VIA EMAIL OR FAX ON
Nov/25/2008

Pure Resolutions Inc.

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (817) 349-6420
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/24/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3/4/5 decompressive laminectomy fusion, PLIF, cages, pedicle screws, local autograft, bone marrow aspiration for fusion, bone putty with 3 day inpatient stay

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 9/2/08 and 8/20/08

Records from Dr. 6/24/07 thru 10/10/08

Discogram and post-discogram CT report 7/22/08

MRI of the lumbar spine with and without contrast report 5/14/08

Records from Dr. 3/20/08 thru 5/8/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year-old male who is status post lamiectomy and discectomy of L3-L4 in 2002, which completely resolved his symptoms. He then had a work injury on xx/xx/xx when he was crawling under a machine to pull out a heavy object. He has back pain radiating to the left lower extremity with tingling. He has had PT, NSAID's, and multiple pain medications. His neurological examination is normal. An MRI of the lumbar spine with and without contrast 05/14/2008 shows degenerative changes at L3-L4 and L4-L5 with left neuroforaminal stenosis. A discogram is positive at L3-L4 and L4-L5. There is no pain on the L5-S1 injection. He is a smoker, and was counseled by the provider on 07/25/2008 to cease smoking. The provider is recommending an L3-L5 decompression and fusion with a three-day inpatient stay.

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

The recommended surgery is not medically necessary at this time. According to the OD Guidelines, "Low Back" chapter, a psychosocial screen is recommended prior to the performance of a lumbar fusion, with confounding issues addressed. There is no documentation of this. In addition, the patient has a long history of smoking and was advised to stop in 07/2008. However, there is no documentation that this was done or attempted. According to the same guidelines, smoking cessation should occur at least 6 weeks prior to a lumbar fusion. Therefore, based on the present data, the surgery is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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