

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior/Posterior Fusion L4-5

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

M.D., board certified in Orthopedic Surgery

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

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker whose date of injury is xx-xx-xx. Apparently he was pulling a

hand jack backwards when his foot was caught, resulting in him falling. He had a lumbar decompression at L3/L4 and L4/L5. Based on his record, he has hemisacralization of L5. His MRI scan from 2007 confirms this finding. There is evidence on the MRI scan of a defect at L4/L5 and L3/L4 from the previous laminectomy, and there is disc degeneration at L4/L5 with bulging at that level. There is a 2-mm retrolisthesis noted on this imaging study and an L3/L4 with similar findings except there is 4-mm retrolisthesis at L3 and L4. There is neural foraminal stenosis at L4/L5 seen. The medical records did not contain information concerning flexion/extension x-rays, nor does it appear that provocative discography has been performed. The current request is for anterior/posterior L4/L5 fusion.

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

Based upon the medical records available, there has not been documentation of instability at L4/L5. The records indicate the L3/L4 level with its 4 mm of retrolisthesis has significant potential for being unstable if investigated. The performance of an L4/L5 fusion in the face of L3/L4 disc problems would not be prudent based upon literature available and the ODG. In addition, the pain generator has not been actively identified. The ODG Guidelines criteria, therefore, have not been met, and the medical provider has failed to provide documentation as to identification of the pain generator, instability, and the condition of the L3/L4 disc above the proposed level of fusion. It is because of the absence of these studies within the records provided that this reviewer is unable to overturn the previous Adverse Determination. The reviewer finds that medical necessity does not exist for Anterior/Posterior Fusion L4-5.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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