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An Independent Review Organization
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DATE OF REVIEW:

Apr/22/2009

IRO CASE #:**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Exploration of Spinal Fusion to include CPT 99222, 22830, 22852, 63030-50, 63035-50, 22630, 22851x2, 22612, 22614x2, 20937, 22842, 20975, 37202-59, 11981-59

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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 1/8/09, 01/20/09

Office notes, Dr. 1/20/06, 03/20/06, 07/11/06

CT myelogram, 4/14/07

CT, 5/1/06, 12/16/08

H&P, 6/27/06

OR report, 6/27/06

Discharge Summary, 6/29/06, 07/14/06

L/S X-rays, 7/11/06

Office note, Dr. 7/12/06

Office notes, 7/27/06, 10/06/06, 12/21/06, 03/08/07, 01/28/08, 05/08/08, 12/22/08, 01/12/09

CT myelogram, 2/19/07

ESI non-certification, 6/20/07

X-ray, 6/29/07

ESI, 7/20/07

Letter of medical necessity, 10/6/08, 01/07/09

Letter, 10/15/0, 03/30/09

Request for surgery, 12/24/08

PATIENT CLINICAL HISTORY SUMMARY

This claimant had a history of lower back, hip and leg pain following an unknown mechanism of injury on xx-xx-xx. He underwent microdiscectomy on the left at L5-S1 for a large disc herniation in September of 2005. The claimant developed severe mechanical back pain with return of bilateral hip and leg pain unresponsive to conservative measures including injections. Subsequently, on 06/27/06, the claimant underwent decompression laminectomy, bilateral root decompression, excision of recurrent herniated disc and anterior posterolateral fusion at L5-S1.

Chronic lower back, leg, and hip pain persisted with positive bilateral straight leg raise, generalized lower extremity weakness with some loss of sensation. The claimant remained unable to work and continued treating with pain management. On 12/16/08, a lumbar myelogram and post CT scan noted moderate spinal canal stenosis at L4-5 with disc bulge causing moderate encroachment upon the dural sac and neural foramen. There were degenerative changes in the facet joints, thickening of the ligamentum flavum posteriorly, moderate spinal stenosis, and moderate bilateral neuroforaminal stenosis. Post surgical changes were seen at L5-S1 with bilateral bony fusion processes noted, that did not appear solid. The dural sac and neural foramen were maintained. Recent office notes indicated the claimant had developed left foot drop with increasing pain and decreased sensation in the bilateral L5 dermatomes. The impression was severe L5 root compression with stenosis at L4-5 and posterior L4-5 decompression with fusion and instrumentation was requested. The surgical request for fusion exploration was non-certified on two separate reviews and an appeal was submitted for review.

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

The clinical information provided suggests the physician is proposing decompression and fusion at L4-5 with no mention of exploring or extending the fusion at L5-S1 and no mention of hardware removal. Based on the information, the reviewer is unclear if the provider is wishing to solely explore the fusion at L5-S1 or also do that in addition to extending the fusion to L4 with a decompression at L4-5. Without a clearer picture of the surgical procedure proposed, addressing the CPT codes provided is not possible. It is not clear if he is wishing to proceed with surgery at L4-5 in addition to L5-S1. The reviewer finds that medical necessity does not exist for Exploration of Spinal Fusion to include CPT 99222, 22830, 22852, 63030-50, 63035-50, 22630, 22851x2, 22612, 22614x2, 20937, 22842, 20975, 37202-59, 11981-59.

Official Disability Guidelines Treatment in Worker's Comp, 2009 Official Disability Guidelines, 14th edition, Low back

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)