

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/03/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Anterior lumbar interbody fusion (ALIF) and a posterior lumbar interbody fusion (PLIF) L5-S1 with CPT Codes 63090, 22558, 22851, 20956, 22612, 63047, and 22840 with a 3 day inpatient length of stay

**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**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 2/25/09, 3/12/09  
MD, 1/29/09, 10/23/08, 7/15/08, 3/27/08  
MRI Lumbar Spine, 12/12/07  
Radiology Report, 3/27/08  
MD, 10/20/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker who had a work-related injury on xx-xx-xx. Apparently she fell on a wet floor and injured the back, right shoulder, and bruised the buttocks and neck. She has undergone various studies including an MRI scan, which revealed a localized disc protrusion at L5/S1 with some osteophyte formation at the L5/S1 level. She has had an EMG/nerve conduction study and also some disc degeneration at L5/S1. She has had an EMG/NCV study indicative of perhaps some mild S1 radiculitis. She continues to have complaints of back pain and radiating leg pain, and surgery has been recommended.

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

As the treating doctor himself has noted, this patient does not have any instability noted on examination, and the request for a discogram to document discogenic pain has been denied. The ODG Guidelines require documentation of instability, and this has not been shown and the treating physician himself has stated that it is not present. The pain generator has not been documented as the discogram as recommended by the treating surgeon was not approved. The records do not indicate that this patient has had any required psychological screening to include this patient as a candidate for lumbar fusion. Based on the Official Disability Guidelines and Treatment Guidelines, this patient does not conform to the screening criteria required to progress to a lumbar fusion. There has been no reason provided as to why the ODG Treatment Guidelines should be overturned in the face of the absence of the screening criteria required. It is for these reasons the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Anterior lumbar interbody fusion (ALIF) and a posterior lumbar interbody fusion (PLIF) L5-S1 with CPT Codes 63090, 22558, 22851, 20956, 22612, 63047, and 22840 with a 3 day inpatient length of stay.

**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)