

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Lumbar 360 Fusion L4-5, L5-S1 w/2 day LOS (63091,22558,22585,22851)

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

1. Adverse Determination letters, 07/02/09, 07/15/09
2. Surgery scheduling slip, 03/12/09
3. initial interview, 03/26/09
4. 04/06/09
5. X-ray post discogram, 06/22/09
6. CT scan of lumbar spine with contrast, 06/22/09
7. M.D., 06/25/09, 05/28/09, 03/12/09, 02/26/09
8. 01/13/06
9. Radiology report, 03/12/09
10. MRI scan lumbar, __/10/08, 06/15/06, 03/02/07
11. M.D., 01/05/09, 11/06/08, 01/29/08, 06/02/08, 04/15/08, 02/27/08, 09/15/08, 01/15/08, 12/04/07, 09/06/07, 07/24/07, 02/15/07, 01/29/07, 05/28/09
12. M.D., 03/10/08
13. Discogram, lumbar spine, 06/22/09
14. ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is a gentleman who was injured on xx/xx/xx. He has undergone three MRI scans, which were available for review. He has complaints about back pain without radiculopathy and

apparently worsening over the years. The most recent MRI scan, as in the previous MRI scans, shows degenerative disc disease, anterior osteophyte formation at L4/L5 and L5/S1, and no loss of disc space height noted. There was no evidence of instability found within these medical records and no attempt to diagnose such instability. A discogram with post discographic CT scan revealed at L4/L5 that there was an annular tear with concordant pain reproduction. At L4/L5 there was internal disc disruption without annular tear and concordant pain reproduction. Current request is for a two-level lumbar fusion.

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

Based upon the documents provided, this patient has degenerative disc disease and L4/L5 and L5/S1 with concordant pain reproduction. Based upon the discogram findings, the records indicate the pain generators have been adequately diagnosed. The ODG panel has determined that it does not support the North American Spine Society Protocols and suggestions for lumbar fusion in the presence of degenerative disc disease. In particular, this is noted because long term outcomes over the past two years have not yet been published, and satisfactory outcomes of two years were not conclusive. The ODG Guidelines do, however, support the use of fusion of one to two levels in patients who have documented instability and degenerative changes. This, however, is not this particular gentleman's case. Not only were flexion/extension views and documentation of instability not documented within the medical records provided, there seems to have been no attempt to document such instability changes. The findings on the MRI scan and CT scan in and of itself do not support a finding of instability. It is for this reason that this reviewer was unable to overturn the previous adverse determinations as this patient does not meet the Official Disability Guidelines and Treatment Guidelines for fusion. Hence, in the absence of any other critical medical evidence, this reviewer is obliged to follow the ODG Guidelines. The reviewer finds that medical necessity does not exist for Inpatient Lumbar 360 Fusion L4-5, L5-S1 w/2 day LOS (63091,22558,22585,22851).

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)