



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/28/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Spine Fusion
Application of Spine Prosthesis Device
LSO
Sagittal-Coronal Control
Non-Emergency Inpatient

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Lumbar Spine Fusion - UPHELD
Application of Spine Prosthesis Device - UPHELD
LSO - UPHELD
Sagittal-Coronal Control - UPHELD
Non-Emergency Inpatient - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI of the Lumbar Spine, M.D., 05/08/08
- Chart Note, M.D., 10/20/08, 06/01/09, 06/24/09
- Request for Pre-Authorization for Surgery, Dr., 06/02/09
- Denial Letter, 06/08/09, 06/24/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient underwent an MRI of the lumbar spine for lumbar region pain that radiated to the right buttock with radiculopathy. Her current medications were reported to be Excedrin Back and Body, Balacet and Lidoderm. She had been diagnosed with segmental instability at L5-S1.

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

The medical records do not indicate the patient has a condition that would meet ODG criteria for lumbar fusion. While the patient is noted to have movement in the lumbar spine of 3.7 mm, ODG indicates instability as being defined by the AMA Fifth Edition Guides on page 379 where it indicates loss of motion segment integrity is defined as greater than 4.5 mm motion in the lumbar spine. Therefore, without meeting ODG criteria, the requested surgery with a spinal prosthesis device is not medically indicated. Postoperative LSO with sagittal and coronal control would not be indicated, and the inpatient hospitalization would not be indicated. This is in line with ODG Thirteenth Edition Web-based Guidelines.

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

- ACOEM - AMERICAN 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)**