

C-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW:

Jun/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy, discectomy, foraminotomy, osteophyctectomy, and medial facetectomy L4-5 level with lateral transverse fusion with 7 day LOS (CPT CODES: 38220, 20931, 22851, 20930, 22840, 63047, 69990, 22845, 22612 and LOS 7 days)

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

MD, 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

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was injured on xx-xx-xx. Records indicate he weighs approximately xxx pounds. He has had extensive conservative care. He has had an MRI scan showing a protruding disc. He has some radiculopathy but predominantly back pain. The current request is for lumbar laminectomy, discectomy, and fusion.

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

This is an individual who has undergone an MRI scan with equivocal findings. There is no evidence of flexion/extension views that were available for review in the medical records. The pain generator has not been identified for ODG Guidelines by the use of discography or other methods. The patient has not had a psychological screening. However, notwithstanding psychological screening, this patient's complaints do not fit the ODG Guidelines for surgery. The pain generator has not been accurately identified. We do, of course, have a single level, but we do not have MRI scan findings or x-ray findings that would indicate that this patient has either instability or other findings indicative for a surgical procedure. The lack of psychological evaluation is an additional negative to approval. Based upon the treating physician's records and the absence of explanation in these records of why the ODG Guidelines should be set aside, given that these are statutorily mandated guidelines and, in fact, compatible with current medical understanding of the indications for treatment, this reviewer was unable to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Lumbar laminectomy, discectomy, foraminotomy, osteophyctomy, and medial facetectomy L4-5 level with lateral transverse fusion with 7 day LOS (CPT CODES: 38220, 20931, 22851, 20930, 22840, 63047, 69990, 22845, 22612 and LOS 7 days).

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)