

Becket Systems

An Independent Review Organization
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DATE OF REVIEW:

Mar/20/2009

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

Inpatient Length of Stay for two (2) days for laminotomy with decompression of nerve roots, including partial foraminotomy and/or excision of herniated intervertebral disc, one interspace lumbar

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, 2/10/09, 2/26/09

5/8/08, 2/12/08, 2/21/08, 2/22/08, 2/25/08, 2/27/08, 2/29/08, 3/3/08, 3/5/08, 3/7/08, 3/10/08, 3/12/08, 5/8/08, 5/14/08, 5/15/08

MD, 10/27/08, 10/9/08, 12/29/08, 10/6/08, 9/23/08, 1/29/09
4/10/08

MRI, 2/5/08

CT Lumbar Spine, 2/5/08, 6/5/08

MD, 2/20/08, 2/16/08, 7/8/08

MD, 3/27/08

MD, 5/15/08

DDE, 5/6/08 and Letters of Clarification, 9/11/08, 10/10/08, 10/24/08

MD, 11/24/08

FCE, 5/20/08, 3/19/08

Emergency Room Note, 2/5/08

CT Cervical Spine, 2/5/08

Pelvis Single View, 2/5/08

CT Thoracic Spine, 2/5/08

Emergency Center, 4/12/08, 4/13/08

County EMS, 6/5/08

Health System Emergency Department, 6/5/08

CT Head, 4/12/08
XR Lumbar Spine, 9/23/08
Psychological Assessment, 3/7/08
Psychotherapy Progress Note, 4/9/08, 6/3/08, 6/10/08
Work Hardening, 4/23/08, 4/24/08, 4/25/08, 4/28/08, 4/29/08, 4/30/08, 5/2/08, 5/8/08,
5/19/08, 6/4/08, 6/5/08
MD, 6/29/08, 7/2/08, 6/17/08, 7/9/08
Operative Report, 7/16/08
MD, 8/21/08, 9/30/08, 10/28/08
MD, 10/27/08, 1/23/09, 2/11/09, 2/18/09
Operative Note, 2/10/09
MD, 10/1/08
Workers Comp Initial Evaluation Report, 2/12/08

PATIENT CLINICAL HISTORY SUMMARY

This is a female injured on xx/xx/xx. According to the medical records provided, she has had denial for artificial disc replacement and a denial at the IRO level. She has had pain management and then subsequent pain management denial. A minimally invasive discectomy has been recommended due to concordant disc at L5/S1 and a disc bulge. She also now has a current request for lumbar laminectomy/discectomy at L5/S1 for concordant back pain and discography at L5/S1 without radiculopathy.

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

At this juncture the patient has been recommended for an artificial disc replacement, a minimally invasive laminectomy/discectomy, and there is now a request for what appears to be an open lumbar laminectomy. The patient has no radiculopathy and hence does not meet ODG Guidelines for a laminectomy/discectomy procedure that is currently being requested. The reviewing physician has not explained why, in the face of the imaging studies including a 6-mm anterolisthesis of L5 on S1 in the presence of a disc bulge and no radiculopathy that further destabilizing the L5/S1 segment with a laminectomy/discectomy would be of benefit to the patient, and more particularly, why this particular procedure, which is contrary to the ODG Guidelines would, in fact, be indicated. It is for this reason, given the lack of medical necessity within the medical records and the lack of conformity with the ODG Treatment Guidelines that this reviewer cannot overturn the previous adverse determination decision. The reviewer finds that medical necessity does not exist for Inpatient Length of Stay for two (2) days for laminotomy with decompression of nerve roots, including partial foraminotomy and/or excision of herniated intervertebral disc, one interspace lumbar,

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)