

# US Decisions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

May/26/2009

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

PLIF Decompression/Discectomy @ L4/5 and 3 day LOS (22612, 22842, 22851, 22630)

**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**

Determination Letters, 4/6/09, 4/16/09

MD, 4/28/09

Clinical Office Notes, 2/23/09, 12/29/08, 12/15/08

Operative Report, 11/3/08

Encounter Summary,

Orthopaedic Group, 3/10/09, 12/2/08, 11/18/08, 9/23/08, 7/29/08

Dr. MD, 3/2/09, 2/5/09, 2/6/09

Hospital, MRI of Lumbar Spine, 12/16/08

Pain Medicine Consultation, 12/15/08

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male injured worker who initially fell. He subsequently underwent an L4/5 microdiscectomy unilateral. He found he did well as far as leg pain was concerned. He had four epidural injections, transforaminal. Decision was made due to ongoing back pain to undergo a fusion at L4/5. The previous reviewer denied this, as he noted that there was a four-day length of stay, which is not medically necessary, and that it was not clear what level of surgery was performed and whether or not he had had epidurals. In actual fact, the records are quite clear as to the previous level. The operative report is present and it is clear that he has had epidurals as well; and they were requesting only for three days. The current request at this time is for a fusion at L4/5.

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

Based upon the ODG Guidelines and the records submitted for review, this reviewer's reason for upholding the previous denial is totally different from the previous reviewer's reason. This man has multi-level spondylosis and the requested surgery would appear to be for treatment of segmental instability secondary to a previous laminectomy/discectomy. The ODG Guidelines require that all pain generators should be identified and treated. In this case, the pain generator has not been identified. A discogram or further discograph CT has not been performed. Particularly in a patient with multi-level spondylosis, this would be of great importance. Furthermore, there have been no flexion/extension x-rays showing spinal instability, and we did not notice psychological screening in the records provided. Based upon the patient's previous surgery at L4/5, this is not a sufficient reason to identify it as the pain generator for the patient's back pain. Hence, the need, as per the ODG Guidelines, for correct and specific pain generator level identification. It is for these reasons, i.e., the lack of identification of the pain generator definitively and the lack of demonstration of mechanical instability, that the previous Adverse Determination could not be overturned by this reviewer. The reviewer finds that medical necessity does not exist for PLIF Decompression/Discectomy @ L4/5 and 3 day LOS (22612, 22842, 22851, 22630).

**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)