

Clear Resolutions Inc.

An Independent Review Organization
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DATE OF REVIEW:

May/18/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpt 360 Lumbar Fusion L4-5, L5-S1 3 day LOS

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

PATIENT CLINICAL HISTORY SUMMARY

This male was injured on xx-xx-xx and has not worked since, except for some odd jobs since his benefits ran out. His MRI scan shows herniation as well as disc desiccation at L4/L5 and L5/S1 with normal levels of both. There is noted to be early spinal stenosis and some foraminal stenosis. He had been treated with epidural steroid injections, and positive relief was noted. He had an EMG/nerve conduction study showing a right L4 radiculopathy. Dr. the surgeon, indicated that he had performed flexion/extension views, and there was no evidence of instability. He has not had his pain generators accurately and definitely identified with provocative discography, but he has been cleared for surgery with a psychological evaluation. Current request is for a 360-degree fusion at L4/L5 and L5/S1.

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

Records indicate this patient does have abnormal discs at L4/L5 and L5/S1. However, he does not have any instability to go along with degenerative findings, and hence, does not meet the ODG criteria. Furthermore, he has not had his pain generator identified with the use of provocative discography. Given the lack of instability and the lack of studies to conform with the ODG Treatment Guidelines, this reviewer is unable to overturn the previous adverse determination. The reviewer finds that medical necessity does not exist for Inpt 360 Lumbar Fusion L4-5, L5-S1 3 day LOS.

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)