

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar surgery to include lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of bone growth stimulator at L4-5, S1 to include CPT codes 63042, 63044, 22612, 20938, 22842, 22830, 22852, and 2 day inpatient stay

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

MD, Board Certified Orthopedic Surgeon
Board Certified Spine 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

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 10/22/09, 10/29/09

Peer Review Report, 10/20/09

Peer Review Report, 10/29/09

MD, 10/12/09, 10/13/09, 9/15/09, 7/21/09,

MRI Lumbar Spine, 9/24/09

Operative Report, Dr. MD, 3/14/09

Orthopaedic Institute, 4/30/09, 3/31/09

Peer Review, 3/25/08

Peer Review, 9/22/08

Peer Review, 11/3/08

Peer Review, 11/14/08

Peer Review, 12/9/08

MD, 1/25/07

PATIENT CLINICAL HISTORY SUMMARY

This is a male patient who has undergone previous discectomy and subsequent fusion at L4/L5 and L5/S1. The patient had an MRI scan on 09/24/09 that showed no stenosis, herniation, root compression, or signs of failure of fusion. The date of injury was xx/xx/xx. The stated reason for the hardware removal with exploration and fusion is that bicortical fixation screws are irritating the sympathetic chain. There is no documentation in the medical record of hardware blocks or other attempts to define this diagnosis.

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

The fusion apparently has been well performed without complications, and there is no evidence of hardware loosening or other irritations in the medical records provided. Blocks, sympathetic or otherwise, have not been performed to confirm the diagnosis that the treating physician has made, that the sympathetic chain is irritated, causing back pain. Given the fact that this pain generator has not been isolated, the recent fusion appears to be in excellent condition. There is no medical justification per the Official Disability Guidelines and Treatment Guidelines to proceed with the indicated requested surgical procedure. The reviewer finds that medical necessity does not exist for Lumbar surgery to include lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of bone growth stimulator at L4-5, S1 to include CPT codes 63042, 63044, 22612, 20938, 22842, 22830, 22852, and 2 day inpatient stay.

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)