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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar discectomy and fusion L5-S1 with 3-day inpatient stay

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

M.D., board certified in Orthopedic Surgery
Spinal 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, 9/8/09, 9/22/09

MD, 3/2/09, 8/25/09, 9/26/08, 7/30/08, 4/23/08, 1/30/08, 11/8/07, 8/20/07, 4/27/07, 1/26/07, 9/14/06, 8/28/06, 3/17/06, 12/16/05, 12/9/05, 8/26/05, 7/11/05, 6/27/05, 2/18/05, 2/5/04, 1/5/04, 10/30/03, 10/27/03, 9/18/03, 7/21/03, 6/9/03, 4/10/03, 2/3/03, 11/7/02, 10/14/02, 4/8/02, 1/28/02, 1/23/01, 1/3/02, 12/10/01, 11/5/01, 9/24/01, 8/23/01, 8/14/01, IRO, 2/11/09

Final Report, undated

MRI & Diagnostic, Operative Report, 7/24/09

Post Discogram CT of Lumbar Spine, 7/24/09

Therapy & Diagnostics, 8/25/09, 9/26/08, 7/30/08, 4/23/08, 11/27/06, 12/16/05, Medical Center, 8/4/07

Operative Report, 11/19/03, 10/15/03, 9/3/03

BHI2, 9/26/08

MD, 10/17/02

MD, 6/14/02, 4/22/02

X-Ray Lumbar, 3/2/09, 8/25/09

MRI Lumbar Spine, 11/18/99

Imaging Report, 1/16/02
Rehab Clinic, 9/12/01
Body Rehab, 8/14/01
Spine
10/8/03
Pain Institute, 9/25/03
MD, 6/10/03
MD, 9/5/01

PATIENT CLINICAL HISTORY SUMMARY

This is a male who was injured on xx/xx/xx. He was apparently injured when lifting a 75-pound box and developed low back pain. He has had extensive care over the years with physical therapy, medications, epidural steroid injections, and transforaminal injections. He has had an MRI scan, which showed a subligamentous herniated L5/S1 without any neural compression. Dr. recommended a total disc replacement, which went through all the appeals and was denied. The request for the disc replacement was based on lack of any instability being documented and lack of any facet degeneration. X-rays have not been presented that show any instability. A psychological screening was performed without any specific recommendations. The claimant has a past history of smoking, although there is no evidence one way or the other, and the current records do not note whether or not he is smoking at this time. He does appear to be using significant amounts of prescription narcotic-type medications including Lorcet and Vicodin and Soma. Current request is for lumbar fusion at L5/S1.

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

This patient has had extensive conservative care as mentioned. He has had a psychological screening, which apparently did not show any negatives vis-a-vis going forward with surgery. However, he does not have any instability documented. He has no facet arthropathy, no instability, and a single-level disease. He therefore does not fall into the ODG patient selection criteria for lumbar spine fusion. He has not had revision surgery. He does not have infection or tumor. Hence, he does not meet any of these screening criteria for fusion. He does, however, have all pain generators identified through the use of MRI scan and discography and/or physical therapy has been completed. X-rays demonstrating spinal instability have not been fulfilled; however, the MRI scan did show disc pathology. His back pathology is limited to one level. The patient fails to fulfill the criteria for fusion under the ODG Guidelines. Hence, until and unless he demonstrates instability, he does not appear to be a candidate as laid out in the statutorily mandated Official Disability Guidelines and Treatment Guidelines. The reviewer finds that medical necessity does not exist for Lumbar discectomy and fusion L5-S1 with 3-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)