

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/02/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal of T10, 11, L1 and L2 instrumentation and a separate right L5-S1 with CPT codes 22852, 22852-80, 63030 and 63030-80 with a 2 day inpatient stay

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

M.D., Board Certified Orthopaedic 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

Adverse Determination Letters, 8/26/09, 9/11/09
ODG Guidelines and Treatment Guidelines
Peer Review Reports, 8/21/09, 9/9/09
MD, 8/11/09, 3/25/09, 1/28/09, 9/8/08, 1/28/08, 5/22/08, 1/28/08
Operative Report, 3/20/08
CT Lumbar Spine, 1/28/09
Radiology, 9/16/08, 2/2/09
MD, 8/28/08
MRI Cervical Spine, 8/11/08
Myelogram and Post CT Lumbar Spine, 7/7/08
RN, 6/5/08
RN, 4/9/08
MD, 4/16/08
Pain Management Procedure Note, 4/2/08

PATIENT CLINICAL HISTORY SUMMARY

This is a male patient who sustained a compression fracture at T12 and underwent instrumental fusion. He was noted to have an L5/S1 disc towards the right. Currently he has

ongoing complaints, and the current request is for removal of instrumentation and a right-sided laminectomy at L5/S1.

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

Based upon the medical records, there is no evidence of the pain generators being identified. There is no evidence that the hardware is painful. Hardware blocks have not been performed according to the records. There is no evidence that the fusion is completely solid. Hence, given the absence of the documentation that the hardware is painful and the absence of concrete proof that the fusion is solid, the removal of instrumentation would not meet the criteria. As far as the L5/S1 disc laminectomy is concerned, given the absence of conservative treatment and hard neurological deficits, as the previous reviewers noted, this procedure also does not meet Official Disability Guidelines and Treatment Guidelines. The reviewing physician has not given us within the medical records any indication of why in this case the Official Disability Guidelines and Treatment Guidelines should be set aside. The reviewer finds that medical necessity does not exist for Removal of T10, 11, L1 and L2 instrumentation and a separate right L5-S1 with CPT codes 22852, 22852-80, 63030 and 63030-80 with a 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)