

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:

Inpatient LOS 2, Lumbar Interbody Anterior Posterior Fusion (22558, 22585, 22851, 63090, 63047, 63091, 77002, 20902, 22612, 22614, 22840)

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

M.D., 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

Adverse Determination Letters, 9/10/09, 9/29/09
ODG Guidelines and Treatment Guidelines
Letter 10/14/09
MRI Lumbar Spine, 5/10/08, Addendum, 5/29/08, 10/10/08
Exam Note, 6/10/08, 6/15/08
Operative Report, MD, 7/8/08
Orthopaedics and Sports Medicine, 7/7/08, 7/21/08, 8/20/08
MD, 10/20/08, 1/12/09, 6/26/09, 8/24/09
EMG/NCV, 11/11/08
Xray, Spine, 2/2/09
Lumbar Myelogram and Post CT, 2/2/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to the records provided, appears to have undergone previous surgery for a bilateral herniated disc at L3/L4. The current imaging studies show minimal disc bulges at L3/L4 and L4/L5. There is a complaint of back pain, and the patient is being proposed for anterior/posterior surgery versus a total disc replacement. From the records, this would appear to be at the L3/L4 level.

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

There are no flexion/extension views noted in the medical records to document that there is instability. Psychological assessment has not been performed to clear the patient for surgery. The patient has not had the pain generator identified, and no provocative discography or other tests have been performed. For a patient with degenerative disc disease as the physician has described at L3/L4 and L4/L5, the criteria set forth in the ODG guidelines needs to be satisfied. In this case, the criteria have not been satisfied, and there is no explanation in the medical record as to why the guides in this particular case should not be followed. The previous adverse determination could not be overturned based on the medical records provided for this review. The reviewer finds that medical necessity does not exist at this time for Inpatient LOS 2, Lumbar Interbody Anterior Posterior Fusion (22558, 22585, 22851, 63090, 63047, 63091, 77002, 20902, 22612, 22614, 22840).

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)