

I-Resolutions Inc.

An Independent Review Organization
71 Court Street
Belfast, ME 04915
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/21/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 discectomy/translateral interbody fusion/transvers procession fusion, pedicle screw fixation/bone graft (63030, 22630, 22612, 22840, 20930)

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

MD, Board Certified Orthopedic Surgeon
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

MD, 6/4/09, 5/19/09, 4/28/09, 2/12/09, 1/22/09
Lumbar MRI, 12/30/08
EMG Report, 4/13/09
Lumbar ESI, 5/12/09
Presurgical Psychological Evaluation, 8/13/09
PT Daily Notes, 12/3/08-2/27/09
Dr. 12/3/08
Follow-up Examination, 12/5/08, 12/23/08, 1/2/09, 2/4/09, 5/19/09, 7/2/09
MD, Ph.D., Office Visit, 3/11/09, 4/13/09
MD, DDE, 6/12/09
Prescriptions, 2009
ODG Guidelines
Adverse Determination Letters, 8/3/09, 8/24/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who apparently, according to the medical records, initially had back pain with radiating leg pain. He subsequently had epidural steroid injections and physical

therapy and various medications. The records show that the current back pain is the issue with only intermittent radicular complaints. EMG/nerve conduction study confirmed radiculopathy. The patient had radicular leg pain with documented imaging findings and pain compatible with an S1 radiculopathy with confirmatory EMG/nerve conduction study. The radiculopathy apparently has resolved except on an intermittent basis and the problem is back pain. The patient has had a psychological screening which clears him for surgery. Current request is for an L5/S1 discectomy with interbody fusion and surgical screw fixation.

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

Based on the ODG Guidelines, this patient does not meet criteria. There is no evidence of instability at L5/S1 with flexion/extension views. There is no evidence that the pain generator has been isolated. Prior to the radicular component improving, the patient did have the screening criteria necessary for a laminectomy and discectomy, however the records indicate that at this point the radiculopathy has resolved except on an intermittent basis and the problem is back pain. Now that the radiculopathy apparently has resolved, the criteria for lumbar fusion per the ODG as mentioned above are not present. The treating surgeon within the medical records does not explain why the ODG Guidelines should be set aside, and for these reasons, the previous adverse determination is unable to be overturned. The reviewer finds that medical necessity does not exist for L5-S1 discectomy/translateral interbody fusion/transvers procession fusion, pedicle screw fixation/bone graft (63030, 22630, 22612, 22840, 20930).

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)