

SENT VIA EMAIL OR FAX ON
Jul/21/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Two Day length of stay for lumbar decompression and fusion with bone marrow aspiration and allograft

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

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

OD Guidelines

Denial Letters 6/4/10, 6/21/10, 6/22/10

PRIUM 6/4/10 and 6/22/10

Neurosurgical Associates 12/21/09 thru 5/27/10

MRIs 1/5/10 and 9/24/09

Injury 1 4/23/10

Dr. 3/4/10

Impairment Rating 3/23/10

NCS 12/2/09

Dr. 10/3/09 thru 11/16/09

List of Medications No Date

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a date of injury xx/xx/xx, when he was lifting and twisting with heavy objects. He complains of low back pain radiating into the right leg. He has undergone physical therapy, pain medications, and a TENS unit. His neurological examination reveals 4+/5 right lower extremity pain. Electrodiagnostic testing 12/02/2009 revealed bilateral S1 radiculopathy and bilateral L4, L5 radiculopathies. An MRI of the lumbar spine 01/05/2010 reveals mild disc bulging at L3-L4 and L4-L5 with mild bilateral neuroforaminal narrowing. At L5-S1 there is a left paracentral and foraminal disc protrusion, which may lightly contact the S1 nerve root. . There is narrowing of the left lateral recess and foramen. Also, there is disc dessication with disc space narrowing at L3-L4 and L5-S1. A psychological evaluation 04/23/2010 found that he was emotionally and psychologically cleared for surgery. The provider is requesting an L5-S1 decompression, posterior interbody fusion, pedicle screws, posterolateral arthrodesis, bone marrow aspiration, and allograft.

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

The proposed surgery is not medically necessary. There are degenerative changes at multiple levels. It is unclear why the provider feels that the L5-S1 is the sole pain generator. In fact the pathology is more to the left at that level, yet the symptoms are to the right. According to the ODG "Low Back" chapter, "All pain generators" should be "identified and treated". It is not clear that this criterion for a lumbar fusion has been fulfilled.

References/Guidelines

2010 *Official Disability Guidelines*, 15th edition

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)