

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Post Lumbar interbody fusion L4/5 L5/S1 inpatient length of stay x 3 days

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

M.D., Board Certified in Orthopedic Surgery
Board Certified in Spinal Surgery

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

Official Disability Guidelines
, 5/18/10, 6/21/10
Neurosurgical 4/30/10
Orthopedics 2/24/10, 4/7/10, 6/2/10
Medical Center 8/31/09, 6/29/09
DNI 4/5/10
Spine Specialists 1/18/10, 1/8/10, 7/27/09, 9/14/09, 12/7/09
DTI 7/16/09, 3/31/10
Health 12/16/09, 10/26/09, 7/30/09, 9/1/09, 9/8/09, 9/15/09, 9/24/09,
9/29/09, 10/6/09, 11/5/09, 11/17/09, 11/24/09, 12/1/09, 12/9/09, 12/14/09
DO 8/11/09, 3/15/10
Medical Center 6/3/09, 6/7/09
6/6/09
Dr. 8/6/09, 3/10/10
BTE Technologies PPE 6/19/09
M.D. 6/17/09, 7/1/09, 8/19/09, 9/2/09, 11/10/09,
12/10/09, 3/4/10, 4/15/10, 5/13/10, 6/10/10
Pain Institute 9/18/09, 10/16/09, 2/26/10
Healthcare 6/3/09 to 7/2/10
Dr., D.C. 9/21/09, 9/22/09, 2/8/10
Medical Evaluators of Texas 8/28/09
Occupational Health Systems 11/9/09
M.D. 5/28/10
6/30/10, 6/16/10, 5/11/10, 5/19/10

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has had a previous lumbar laminectomy performed. He complains of back pain and leg pain but predominantly leg pain. He has documented neurological deficits, which are supported by an MRI scan and an EMG/nerve conduction

study as well as physical findings. He had a psychological evaluation, and there does not appear to be any obvious issue with his psychological status; however, Dr. reported multiple positive Waddell's signs. The current request is for Post Lumbar interbody fusion L4/5 L5/S1 inpatient length of stay x 3 days.

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

Based upon the patient's medical records, the patient has certainly exhausted the conservative treatment modalities as recognized and endorsed under the Official Disability Guidelines and Treatment Guidelines. The patient has had one previous laminectomy. After two laminectomies, the ODG Guidelines would recommend fusion. In addition, there is no evidence on flexion/extension views of instability that would conform to the ODG requirements of AMA Guidelines of instability, in particular, any segmental movement of greater than 20 degrees of angular motion or 4.5 degrees of translation. The medical records do not contain any information that would explain to the reviewer why the previous adverse determination should be overturned or why the Official Disability Guidelines and Treatment Guidelines should be set aside in this particular case. It is for this reason that this reviewer could not overturn the previous adverse determination. The reviewer finds that medical necessity does not exist at this time for Post Lumbar interbody fusion L4/5 L5/S1 inpatient length of stay x 3 days.

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)