

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Feb/17/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Inpt Posterior Lami Fusion L4-S1  
22612, 22614, 20931, 20930, 20936, 22842, 22851, 22630

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., board certified in Orthopedic Surgery and Board Certified in Spine 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

ODG Guidelines  
Adverse determination letters, 1/7/10, 1/22/10  
XXXX 4/6/09  
Ph.D. 6/8/09  
MRI, 12/12/08  
Notes, 3/2/09, 3/18/09  
XXXXX 2/12/09, 4/15/09  
Surgery Center 3/2/09, 3/30/09  
Physical Therapy 1/9/10 to 1/21/10  
Patient Evaluation 3/27/09

### PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker according to history who was injured lifting a heavy object. He has had back pain and left lower extremity radiculopathy in an L4/L5 distribution. There is weakness of the extensor hallucis longus and also straight leg raising and decreased sensation over the same dermatome. The patient has had oral medication, transforaminal epidural steroid injection times two, and physical therapy. The patient continues to have symptomatology. Psychological exam has been performed, clearing the patient for surgery. The request is for lumbar fusion at two levels.

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

Based upon the ODG Guidelines this patient does not meet the criteria for fusion. Based on the records submitted, including the imaging studies (which do support one another), the patient has radiculopathy and has asymptomatic radiculopathy. However, as far as fusion, he does not meet the ODG criteria. He has predominantly radicular problems. He has no previous laminectomy surgery, and there is no evidence of instability noted in the medical records. It is for this reason the previous adverse determination for lumbar fusion surgery cannot be overturned. The reviewer finds that medical necessity does not exist for Inpt

Posterior Lami Fusion L4-S1 22612, 22614, 20931, 20930, 20936, 22842, 22851, 22630.

**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)