

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/30/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

L5-S1 ALIF w 1 day LOS 63090-22558-22851-20931

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

M.D., Board Certified Orthopedic 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**

Official Disability Guidelines, Patient Selection Criteria for Lumbar Spinal Fusion  
9/21/10, 10/8/10  
Back Institute 8/14/10 to 9/7/10  
Imaging 6/15/10  
Occupational Medicine 7/21/10, 8/4/10, 6/21/10  
Spine Institute, PA 7/2/10  
M.D. 8/26/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is an injured worker with a previous spinal cord injury and rheumatoid arthritis who is xx years of age. The patient has had complaints of back pain and right leg pain, 10/10. Only medications have helped. Physical therapy, epidural steroid injection, chiropractic, and psychological evaluations have made it worse. He has had flexion/extension views which show no flexion/extension or rotational instability, and degenerative changes at L3/L4, L4/L5, and L5/S1. There is loss of disc space height at L5/S1, and this is being classified as "vertical instability." There is facet arthropathy associated with this loss of disc space height, and there is a 4-mm disc bulge documented. Current request is for L5/S1 anterior interbody fusion.

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

The Official Disability Guidelines require that not only conservative care be exhausted as has occurred in this case, but also that there be imaging findings compatible with the patient's complaints. The patient's complaints of leg pain are not supported by the imaging studies

available in this particular instance. Furthermore, the pain generator has not been isolated, as the pain management procedures have failed to provide even temporary relief other than an epidural steroid injection, which is said to have provided one to two days' relief. No specific blocks were noted within the medical records, and a discogram does not appear to have been performed. Notwithstanding this, the patient would not meet the ODG criteria for a fusion, as he has not had two previous discectomies and/or does not have an instability as determined by the AMA Guides. For these reasons, the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for L5-S1 ALIF w 1 day LOS 63090-22558-22851-20931.

**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)