

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Arthroplasty L4-5, Lumbar Fusion L5-S1

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

M.D., Board Certified Orthopedic Surgeon
Board Certified 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

ODG, 2010, Low Back
Corporation 8/2/10, 8/20/10
PA 11/25/09
Clinic 5/22/09
Institute 11/20/08 to 2/19/10
Spine Institute 2/17/10, 2/4/10, 1/8/10, 7/18/09, 7/31/09
MRI 2/4/10
MRI 7/27/09
Occupational Medicine 7/23/09
COPE 3/23/10
Review 6/18/10

PATIENT CLINICAL HISTORY SUMMARY

This is a patient with complaints of back pain and some tingling into the lower extremities. The patient has undergone epidural steroid injections without relief. MRI scan showed a disc protrusion at L5/S1, and discogram showed pain and reproduction of symptoms at L4/L5, no pain at L5/S1. A post discographic CT scan revealed that the L4/L5 disc was normal, and the L5/S1 disc showed a small protrusion with annular tear. Flexion/extension views, both lateral and anterior/posterior, did not reveal any instability. Current request is for an arthroplasty at L4/L5 and fusion at L5/S1.

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

Based on the Official Disability Guidelines and Treatment Guidelines, this proposed Lumbar Arthroplasty L4-5, Lumbar Fusion L5-S1 is not medically necessary in this patient's case. With regard to the request for fusion, the patient does not conform to the ODG criteria as there is an absence of instability. As far as arthroplasty is concerned, this is a procedure that is not recommended by ODG for the lumbar spine. The provider in the case has not explained why there should be an exception to the ODG in this patient's case. The reviewer finds there is not medical necessity for Lumbar Arthroplasty L4-5, Lumbar Fusion L5-S1.

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)