

I-Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpt LOS 3 Anterior posterior Lumbar Discectomy & 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 and 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 Low Back

, 8/24/10, 9/7/10

Med article 8/1/02

M.D. 1/29/07 to 7/8/10

Medical Center 10/31/05

General Hospital 2/20/07

MRI & Diagnostic 11/23/09

4/6/10

Diagnostic 4/1/10

Network 10/14/08

Diagnostic 7/23/08, 5/7/08, 1/29/07

BHI2 1/4/08

Hospital 8/21/07

MRI 12/18/06

Diagnostic Imaging 7/27/05

Imaging 3/22/07

Systems 1/11/10

6/2/2000

M.D. 2/27/09

Independent Review Incorporated 2/10/09

11/11/08

1/21/08

M.D. 7/11/07

Healthcare Group 10/4/05 to 1/23/07

Spine Associates 10/4/05, 9/6/05, 5/24/05, 7/16/05

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured worker who was injured in a MVA on xx/xx/xx. He has undergone a previous L5-S1 laminectomy (10/31/05). He currently has complaints and documentation of worsening of L5 radiculopathy with disc space collapse and recurrent disc protrusion.

Current request is for an anterior/posterior discectomy and fusion.

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

This patient does not satisfy the ODG criteria for lumbar fusion. The AMA Guides for instability have not been satisfied as far as this reviewer could determine from the records presented for review. (See AMA guides, 5th Edition) Flexion/extension views were not present within the records. Although there is collapse of the disc space, there is no indication of translation or rotational instability. The patient has also undergone just one previous laminectomy, and that also would not satisfy the ODG criteria in this situation. According to the ODG criteria, spinal fusion is not recommended unless there is objectively demonstrated severe structural instability. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Inpt LOS 3 Anterior posterior Lumbar Discectomy & 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)