

Becket Systems

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: September 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Two day inpatient discectomy, arthrodesis with cages, posterior instrumentation, BGS implantation L3-4, L4-5 and 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, American Board of 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 TWC 2010 Low back, Lumbar and Thoracic

Inc., 8/13/10, 8/23/10

M.D. 5/18/10 to 7/27/10

M.D. 6/22/10

6/22/10

Institute 1/12/10

Injury Care 9/15/08

3/10/09, 7/8/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a long history of low back pain complaints. He has seen multiple medical providers. The most recent medical provider has recommended that this patient undergo three-level lumbar fusion with decompression. It is noted in the medical provider's history that the patient has some bladder incontinence and some erectile dysfunction. He is on Vicodin and was prescribed Viagra. There was no consideration to evaluate this further through a voiding cystometric urethrogram. He has had flexion/extension views performed, which show no translational motion. He does, however, have a fixed L3/L4 retrolisthesis of 3 mm. Current request is for L3/L4, L4/L5, and L5/S1 decompression and instrumented arthrodesis.

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

As far as instability is concerned, the fact that the man has a fixed retrolisthesis does not lead to a definitive diagnosis of instability. In fact, flexion/extension films were taken and read by a radiologist and categorically stated to show no translation. This was also noted by another medical provider. Based on the above findings, given the fact that this is a three-level fusion without translation or rotational instability, this patient does not meet the entry screening criteria of the statutorily mandated Official Disability Guidelines and Treatment Guidelines. The treating physician has not given this reviewer any information as to why the Official Disability Guidelines and Treatment Guidelines should be set aside in this particular patient's case. It is for this reason that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for two

day inpatient discectomy, arthrodesis with cages, posterior instrumentation, BGS implantation L3-4, L4-5 and 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)