

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

360 Fusion and decompression at L4-5 w/ 2 day LOS

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

Official Disability Guidelines
Insurance provider 1/14/11, 2/7/11
Surgery Scheduling Slip/Checklist 12/10/10
Clinic 7/13/10 to 3/1/11
Clinic 4/28/10 to 1/7/11
Clinic 12/29/10
Diagnostic Imaging 7/27/10
M.D. no date
DO no date

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who is stated to have had two previous laminectomies. However, the levels are not identified, and the imaging studies do not confirm that the patient has actually had these laminectomy procedures. The patient also complains of neck pain as well as the low back pain with radiating pain to the legs. On one examination, there was weakness in the L5 enervator musculature with sensory defects. In other physicians' reports, this was not the case. An MRI scan of the lumbar spine was available for review showing at L4/L5 a large broad-based disc bulge with right paracentral disc protrusion effacing the right anterior aspect of the thecal sac. This material occupies the inferior aspect of both the intraarticular foramen, more pronounced on the left than the right. An x-ray was taken with flexion/extension views. No motion was documented. There was some retrolisthesis noted; how much retrolisthesis was not measured. The patient has had psychological screening, which shows no contraindication to the procedure, and the patient does not smoke. He is stated to have had a history of alcoholism.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

This is a XX-year-old male with complaints of back pain and leg pain with previous laminectomy and discectomy done in 19XX and 20XX. He has had conservative care to include physical therapy, epidural steroid injections, and medications but has not had relief. Flexion/extension films were not measured as to motion. Instability has not been documented. It is unclear if the two previous laminectomies were done at the same L4/L5 level, or at different levels. There is no documentation, and therefore the ODG criteria for fusion may or may not be met, depending on the levels of these procedures.

The patient does not meet the other entry screening criteria of the ODG Guidelines for fusion. He does not have significant spondylolisthesis or instability. While the patient certainly may have radiculopathy and may be a candidate for decompression, the ODG entry criteria for a fusion has not been met. For this reason, the previous adverse determination could not be overturned. The treating physician has not provided an explanation for why in this particular case the guidelines should be set aside. The reviewer finds no medical necessity at this time for 360 Fusion and decompression at L4-5 w/ 2 day LOS.

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)