



Notice of Independent Review Decision

DATE OF REVIEW: 08/02/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior Lumbar Interbody Fusion
Posterior Lateral Fusion at L4-L5 and L5-S1
Pedicle Screws
Posterior Laminectomy to Decompress Lateral Recess
Three Day Inpatient Stay

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

Board Certified in Orthopedic 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Anterior Lumbar Interbody Fusion – UPHELD
Posterior Lateral Fusion at L4-L5 and L5-S1 – UPHELD
Pedicule Screws – UPHELD
Posterior Laminectomy to Decompress Lateral Recess – UPHELD
Three Day Inpatient Stay – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Clinical Evaluation – Summary, Clinics, 12/17/08
- Lumbar Spine MRI, Health System, 06/07/10
- Addendum, Health Systems, 06/04/10
- Psychological Evaluation, Ph.D., 08/31/10
- Report of Psychological Testing, Dr., 08/31/10
- Office/Outpatient Visit, M.D., 12/13/10
- Evaluation, D.O., 02/08/11, 03/15/11, 04/11/11, 05/11/11, 06/08/11, 07/11/11
- Lumbar Spine X-rays, M.D., 02/08/11
- Pre-Authorization Request, Dr., Undated
- Denial Letters, , 03/10/11, 05/27/11, 06/21/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient injured his low back at work on xx/xx/xx while working. He had surgery in 1995 to remove disc fragments at L4-L5 associated with the injury and two months later another surgery to remove fragments at L5-S1. The pain apparently remained significant, and has he been treated with medications, injections and physical therapy, but none of the treatments had provided significant benefit. It was recommended the claimant undergo a posterior L5-S1 laminectomy to decompress his lateral recess, S1 nerve root on the right.

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

At this time, the medical records provided for my review fail to adequately document a functional spinal unit failure with mechanical back pain with instability as the ODG requires, and there are no other documented objective clinical findings to meet any other ODG criteria for lumbar fusion.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM - AMERICAN 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)**
- AMA GUIDES 5TH EDITION**