IRO REVIEWER REPORT - WC

DATE OF REVIEW: 04-19-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior & Posterior Interbody Fusion, L4-5 with Instrumentation

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

Certified by the American Board of Orthopaedic Surgery
General Certificate in Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

X 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.

Date of injury	Claim #	Type of Review	ICD-9/DSMV	HCPCS/ NDC	Upheld Overturn
		Prospective	722.10	20936	Overturn
		Prospective	722.10	20974	Overturn
		Prospective	722.10	22558	Overturn
		Prospective	722.10	22612	Overturn
		Prospective	722.10	22842	Overturn
		Prospective	722.10	22845	Overturn
		Prospective	722.10	22851	Overturn
		Prospective	722.10	62351	Overturn
		Prospective	722.10	63047	Overturn
		Prospective	722.10	63090	Overturn

		Prospective	722.10	99234	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Non-Certification of Service/Procedure Initial 03-05-07
Result of Reconsideration-Non-certification determination Upheld 03-12-07
Physician Notes (History and Physical) 10-09-06, 12-04-06, 01-26-07
Operative Report 05-29-04 and 01-10-07
Discharge Summary 05-29-04 to 05-30-04
Physician Report (Reexamination) 02-10-06
Physician Report (request for independent review) 04-24-06
Orthopaedic Report 01-19-07
Letter of Medical Necessity for Lumbar Discectomy and Fusion 02-21-07
Surgery Reservation Sheets 02-09-07, 02-28-07
TX Workers' Compensation Work Status 10-07-06, 12-01-07
Imaging Report (Lumbar Spine) 09-03-02
Radiology Report (MRI of the Lumbar Spine) 02-10-05
EMG/NCV of the Lower Extremities 02-14-05
Magnetic Resonance Imaging of the Lumbar Spine with and without Contrast 10-10-05
Radiology Report (Post Lumbar Discogram CT) 01-10-07
American Academy of Orthopaedic Surgeon. Orthopaedic Knowledge Update: Spine 3

PATIENT CLINICAL HISTORY [SUMMARY]:

This male is status post lumbar laminectomy for back pain. It was noted that he had good results and full recovery with that surgery. While at work, injured his lumbar spine, getting outside of truck and missed step, causing strain of lower back. This injury apparently resulted in recurrence of his radicular complaints. He had extensive physical therapy, multiple epidural steroid injections with some improvement in his leg symptoms. On 05-29-04 underwent revision lumbar laminectomy secondary to persistent back pain and radicular complaints. Documented some improvement with leg symptoms but continued back pain with referred pain to hips and thighs. Repeat MRI 10-10-05 showed left sided disc herniation at L4-5. A lumbar discogram on 01-10-07 was performed. The IW had concordant pain reproduction at the L4-5 level as well as an abnormal nucleogram. The treating physician requests a lumbar fusion for this injured worker.

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

The IW has had all conservative treatment of his failed surgical back and clearly has instability and facet arthrosis syndrome at the L4-5 level. The surgeon is

planning the accepted appropriate treatment for this patient, that being a L4-5 360 fusion, AKA anterior/posterior L4-5 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**
- X **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)**