

DATE OF REVIEW: 5/2/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Preauthorization for L4-L5 and L5-S1 anterior lumbar interbody fusion (AFIF) posterior stabilization with right ICBG with a three (3) day length of stay (LOS).

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

This case was reviewed by a board certified orthopedic surgeon on the external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>Service Being Denied</i>	<i>Billing Mod</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
722.10	22558		Prospective					Uphold
722.10	22612		Prospective					Uphold
722.10	20938		Prospective					Uphold
722.10	22842		Prospective					Uphold
722.10	22845		Prospective					Uphold
722.10	22851		Prospective					Uphold
722.10	20931		Prospective					Uphold
722.10	22614		Prospective					Uphold
722.10	76003		Prospective					Uphold
722.10	22858		Prospective					Uphold

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 4/23/07
2. Determination Notices – 1/19/07, 1/25/07
3. Surgical Preauthorization Request form – 1/11/07
4. Records and Correspondence from MD – 3/21/07, 3/27/07
5. Utilization Review Findings – 1/19/07, 1/25/07
6. Records and Correspondence – 3/2/06-12/14/06
7. Designated Doctor Report – 11/2/06
8. Peer Review Report – 2/7/06
9. Records and Correspondence – 1/31/06
10. Records and Correspondence – 7/13/05
11. Records and Correspondence – 6/10/04-2/3/06
12. Records and Correspondence – 2/11/05
13. Records and Correspondence – 6/23/04

PATIENT CLINICAL HISTORY:

This case concerns a female who sustained a work related injury. Records indicated that while lifting a large 80-pound bin, she felt a pop and warmth in her low back followed by stabbing pain in both lower extremities. Diagnoses have included internal disc disruption (L4-L5, L5-S1) and radiculopathy. Evaluation and treatment for this injury has included medications, a discography, and steroid injections.

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

The physician reviewer indicated that the literature does not support the role of fusion surgery for multiple levels of lumbar degenerative disc disease. The physician reviewer noted that fusion surgery is not likely to be successful and provide relief of this patient's pain. The physician reviewer explained that fusion surgery is not medically necessary for treatment of this patient's condition. The physician reviewer indicated that the article by Van Tulder MW, et al. is a metanalysis of the literature that does not support fusion surgery for the patient's condition. Therefore, the physician reviewer concluded that the requested L4-L5 and L5-S1 anterior lumbar interbody fusion (ALIF) posterior stabilization with right ICBG with a three (3) day length of stay (LOS) is not medically necessary for treatment of this patient's condition.

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)

van Tulden MW, et al. Outcome of invasive treatment modalities on back pain and sciatica: an evidence-based review. Eur Spine J. 2006 Jan;15 Suppl 1:S82-92.