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IRO NOTICE OF DECISION – WC

DATE OF REVIEW: 05-05-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of preauthorization approval for Anterior lumbar interbody fusion

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

Certified by the Board of Neurological Surgery
General Certificate in Neurological 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.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/Overturn
		Prospective	722.10	22558	Overturned
		Prospective	722.10	22851	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization denial (04-12-07 and 04-19-07)
Physician notes and evaluations from 11-08-05 through 04-03-07
MRI/CT/x-ray reports (including bone scan)
Electromyographic evaluation dated 09-25-06

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant injured self tripped over the leg on a conveyor belt and fell on her left side at work. Examined and diagnosed with trochanteric bursitis. Treatment included medications, physical therapy and steroid injection. The presence of low back pain led to a further work-up of the low back.

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

The CT scan and some of the lumbar x-rays identified an L5 pars defect (spondylolysis) with lateral disc herniation at L5-S1. The clinical reports link the low back and leg symptoms to these findings. One imaging test also demonstrated a spondylolisthesis (CT scan).

It is clinically reasonable for failure of non-surgical treatments and injections to recommend stabilization at L5-S1 in this case by any method preferred by the provider. Pars fractures are known to not heal spontaneously. The persistent back and left leg pain may reasonably be caused by the instability, fracture, and lateral disc herniation.

Thus, arthrodesis surgery at L5-S1 is reasonable in this case.

ACOEM guidelines no longer apply at this late juncture after injury. “If non-operative treatment fails, the mainstay of surgical treatment for adult patients with low-grade acquired spondylolytic spondylolisthesis is fusion,…” can be found in the review article: “Surgical management of Spondylolisthesis overview of literature,” by S Sadiq, et.al., from the Charing Cross Hospital, Imperial College School of Medicine, in London. [December 2005 Neurology India, Volume 53, Issue 4, pp: 506-511].

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 JUDGMENT, 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)