



Notice of Independent Review Decision

DATE OF REVIEW: 11/02/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical necessity of the previously denied CPT codes: 63047, 63407, 22558, 22585, 22612, 22614/Laminectomy, Single Vert Seg: Uni/bilateral, Arthrodesis, Anterior Interbody W/Decompression, each Additional, Arthrodesis, Posterior- posterior lateral Each additional w/Inclaimant one-day length of stay.

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

Neurological 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)

The previously denied request for CPT codes: 63047, 63407, 22558, 22585, 22612, 22614/Laminectomy, Single Vert Seg: Uni/bilateral, Arthrodesis, Anterior Interbody W/Decompression, each Additional, Arthrodesis, Posterior- posterior lateral Each additional w/Inclaimant one-day length of stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Notice to CompPartners, Inc. of Case Assignment dated 10/24/07.**
- **Request for a Review by an Independent Review Organization dated 10/18/07.**
- **Review Determination dated 9/11/07, 8/24/07.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 10/22/07.**
- **Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 10/24/07.**

- Lumbar Surgery Posting Form (unspecified date).
- History of Present Illness dated 8/9/07.
- Procedure Note dated 5/29/07.
- Post Disco Gram Lumbar CT dated 5/29/07.
- Lumbar Disco Gram dated 5/29/07.
- Lumbar Spine MRI dated 12/8/06.
- Pathology Consultation dated 8/8/07.
- Fax Cover Sheet dated 10/26/07, 10/24/07, 10/22/07.

CLAIMANT CLINICAL HISTORY [SUMMARY]:

Age: xxyear
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Not provided for this review.

Diagnosis: 722.52 lumbar disk degeneration.

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

The claimant is a xx-year-old male who sustained an injury on xx/xx/xx. The exact nature of his injury was not described in the documentation provided. The diagnosis is 722.52 lumbar disk degeneration. The claimant underwent an unknown lumbar spinal procedure by a Dr. in 1999. Aside from that surgery, there was no documentation of any other treatment that the claimant had received for his diagnosis. There was no indication that physical therapy, epidural steroid injections, or other modalities, other than oral medications, have been provided to the claimant. The claimant did undergo a diskogram of the lumbar spine on 5/29/07, which revealed no pain with injection at L3-4, L4-5, and L5-S1 was not done due to the inability to place the needle in the disk space. However, a post diskogram CT revealed a very small annular tear at the L4-5 level. The Official Disability Guidelines do state that selection for the claimant's lumbar spinal fusion after six months of conservative care can include claimants that are properly selected and have undergone screening for psychosocial variables. Claimants who do have degenerative disk disease with spinal segment collapse with and without neurologic compromise after six months of recommended conservative therapy can be considered for therapy. However, it is unclear exactly how much treatment this claimant has received, and it is clear that the L4-5 disk was not painful on injection on the diskogram. Considering the lack of information and inconsistency with the diagnostic diskogram, this reviewer cannot recommend surgical management for this claimant at this time. According to a note from Dr. on 8/9/07, the claimant was relating 9/10 back pain, but further states that he is employed as a mechanic, working full time, and is able to walk more than three blocks. Because of the claimant's functionality as well, this reviewer cannot agree to approve surgical treatment as requested as well.

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 AND 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).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

