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Notice of Independent Review Decision

DATE OF REVIEW: 10-25-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Minimally invasive total lumbar laminectomy L3, L4, & L5 and microdisectomy L4-5, L5-S1, TLIF L5-S1 left with a 3-day hospital stay

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

Certified by The American Board of 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/ Overturn
xx.xx.xx	xxxxxxxx	Prospective	724.4 722.10 724.2		1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Determination, not certified, dated 08-14-07 & 09-27-07

MRI lumbar spine dated 05-20-02, 01-21-04, & 01-31-07

Physician consultation report dated 05-07-07

Progress note dated 01-20-04

Impairment rating determination dated 03-23-98

ODG Guidelines: Fusion (spinal)

ODG Guidelines: Indications for Surgery – Discectomy / laminectomy

PATIENT CLINICAL HISTORY [SUMMARY]:

On XXXX, the claimant was noted maximum medical improvement and assigned an 8% whole person impairment rating for lumbar spine injury. The claimant was surgically treated and is status post left microdiscectomy at L5-S1 on 01-13-98.

On 05-20-02, a lumbar MRI was done noting the surgical defect at L5-S1. A small herniation was noted proximal. A repeat MRI was completed on 01-21-04 noting bulging at the lower three levels, focal disk protrusion at L5/S1 and the prior surgical defect.

The progress note of 01-20-04 noted lower extremity symptoms walking 100 yards. A third lumbar MRI was obtained on 01-31-07. Degenerative disc disease was noted at L2-3, L3-4, and L4-5. Possible impingement to the left L5 nerve was also noted.

On 05-7-07, a consultation and electrodiagnostic studies were completed. A modest nerve root aggravation was noted and thought to be chronic. No other electrodiagnostic findings identified.

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

According to the Physician Reviewer, based on the records presented for review, there is no clinical indication for a four level lumbar laminectomy and discectomy and lumbar fusion. The claimant has significant degenerative changes, but there is no objectification of instability, infection, or fracture. Therefore, as per the Official Disability Guidelines, the requirements for lumbar fusion are not met. Furthermore, one does not address all the levels in the spine at one time.

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)**