

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 9/13/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. 36090.62 - Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment. Two Surgeons
2. 22558 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
3. 22851 - Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace
4. 20931 - Allograft for spine surgery only; structural
5. 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)
6. 63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended the University of Pittsburgh School of Medicine after completing his undergraduate degree at the University of Virginia. He completed an internship and residency at Pennsylvania State University. He has been actively practicing since 1990. He is a member of the American Academy of Orthopaedic Surgeons and the American Medical Association.

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

1. 36090.62 - Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment. Two Surgeons Upheld
2. 22558 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar Upheld
3. 22851 - Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace Upheld
4. 20931 - Allograft for spine surgery only; structural Upheld
5. 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique) Upheld
6. 63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Independent Review organization note dated 8/23/2007
2. Request form note dated 7/19/2007
3. Denial note dated 9/7/2007

4. Clinical note dated 6/5/2007
5. Clinical note dated 6/29/2007 and 8/16/2007
6. Medical review of case assignment note dated 8/28/2007
7. Clinical note dated 9/7/2007
8. Clinical note dated 8/31/2007
9. Clinical note dated 8/28/2007
10. Clinical note dated 8/10/2007
11. IRO request form note dated 8/23/2007
12. Independent review organization note dated 7/19/2007
13. Clinical note dated 6/5/2007
14. Clinical note dated 9/29/2007 to 8/16/2007
15. Clinical note dated 9/20/2006
16. Clinical note dated 9/7/2007
17. History and physical exam note by MD, dated 6/7/2007
18. Physical examination note dated 9/7/2007
19. Clinical note dated 4/17/2007
20. Surgery scheduling slip note dated 3/15/2007
21. Clinical note dated 4/5/2007
22. Case management note dated 6/22/2007
23. X ray report by MD, dated 11/10/2006
24. X ray report dated 11/10/2006
25. Peer to Peer review by MD, dated 6/5/2007
26. Follow up note by MD, dated 3/15/2007 to 6/14/2007 multiple dates
27. Clarification note by MD, dated 3/14/2007
28. Consult note by MD, dated 3/8/2007
29. Follow up note by MD, dated 3/5/2007
30. Clinical note by MD, dated 2/27/2007
31. Follow up note by MD, dated 12/11/2006 to 2/12/2007 multiple dates
32. Consultation note by MD, dated 11/27/2006
33. X ray report by MD, dated 11/10/2007
34. Clinical note dated 11/7/2006
35. Clinical note by MD, dated 9/29/2006
36. X ray report by MD, dated 9/19/2007
37. Physical therapy note
38. Office visit note dated 9/22/2006
39. Clinical note by MD, dated 10/6/2007
40. Physical therapy note dated 6/22/2006
41. Progress treatment note dated 10/30/2006
42. Office visit note by MD, dated 10/6/2006

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This female was injured while at work. At that time she was lifting a patient who weighed 245 pounds. It was also reported that she was involved in a motor vehicle accident. The injured worker complained of a dull ache in the thoracic and lower lumbar area with muscle spasms radiating into her upper back and legs. She had sharp pain in her low back radiating into both legs, right more than left. There was also a note of burning pain in her low back radiating into her groin. A MRI from 9/19/2006 showed a mild diffuse disc bulge at L5. The injured worker underwent a left SI joint block injection and has been on multiple medications.

At this time, the request for 360 degree fusion with 2 day length of stay is under review for medical necessity.

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

Based on all of the information presented, the previous denial should be upheld. According to the records, the tenderness is diffuse, not well localized. Electrodiagnostics were normal. A discogram was positive for pain complaints at more than the single level put forth for surgery. There was no instability. The CT scan does not confirm progressive loss of height.

Taking into account the Official Disability Guidelines, there is obviously no spondylolisthesis. There is no documented segmental instability. There is no documentation of progressive degenerative change with progressive loss of disc height. There is certainly no evidence of infection, tumor or deformity. There is no neurologic deficit as

documented by the normal electrodiagnostics. As such, this injured individual falls outside of the selection criteria and the request for 360 degree fusion with 2 day length of stay is denied.

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
- X 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)