

# Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX  
75038  
972.906.0603 972.255.9712  
(fax)

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## Notice of Independent Review Decision

**DATE OF REVIEW:** APRIL 17, 2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed anterior lumbar interbody fusion L5-S1(63090-62, 22558, 22851, 20931)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

**REVIEW OUTCOME**

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

Upheld (Agree)

Overturned

(Disagr

ee)

Partially Overturned

(Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.2	63090	62	Prosp	1					Upheld
722.2	22558, 22851, 20931		Prosp	1					Upheld

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**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a work related on the job injury on xx/xx/xx. She had an apparent prior lumbar incident in xxxx with care provided by Dr. with pain reported in the low back and right lower extremity. Her work incident was an apparent sprain or strain. She has had reported chiropractic care, physical therapy and medication management without symptom resolution.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

On xx/xx/xx, she had a lumbar MRI that showed a disc bulge at L4-5 and a disc protrusion at L5-S1 with mobic end plate changes. On 10/29/07, Dr. reported diffuse tenderness of the low back and no objective neurological deficits. She was provided a home stimulator and garment by Dr.; however the benefit with its use was not discussed.

On 2/19/08, the patient had a psychological pre-surgical screen with Dr. office. She was approved for surgery psychologically.

There were utilization review denials for the proposed spine surgery. These denials cited the *Official Disability Guidelines*. There was no report of any trial of antidepressant treatment, work conditioning or confirmation of the specific pain generator. Moreover, there was a prior history of low back pain.

Thus, the request is not approved as a medical necessity as lesser levels of care have not been exhausted and she does not meet *Official Disability Guidelines* criteria for a fusion procedure.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES  
*TWC Low Back, 5<sup>th</sup> Edition, 2007.*