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Notice of Independent Review Decision

DATE OF REVIEW: 02-19-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar laminectomy with fusion and instrumentation L3-4, L4-5
Length of stay: one-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 Orthopaedic 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/ NDC	Upheld/ Overturned
		Prospective	724.02	22612	Upheld
		Prospective		22614	Upheld
		Prospective		22630	Upheld
		Prospective		22632	Upheld
		Prospective		22842	Upheld

		Prospective		20938	Upheld
		Prospective		20975	Upheld
		Prospective		37202-59	Upheld
		Prospective		11981-59	Upheld
		Prospective		22851	Upheld
		Prospective		99222	Upheld
		Prospective		22830	Upheld
		Prospective		22852	Upheld
		Prospective		63030-50	Upheld
		Prospective		63035-50	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Appeal Decision Notice (and review rationale) dated 11-19-07 and 12-06-07
Physician progress notes dated 10-29-07, 11-12-07, 11-29-07, and 01-08-08
Operative Reports dated 11-09-07 and 12-27-07

Physical Therapy note and Functional Capacity Evaluation dated 12-20-07
Radiology Reports for CT Lumbar Spine Myelogram and Lumbar Myelogram
dated 11-09-07

Pre-authorization Requests 11-14-07 and 12-3-07

MRI of Lumbar Spine dated 10-04-07

Official Disability Guidelines (ODG) Low Back Lumbar and Thoracic Acute and
Chronic; Patient Selection Criteria for Lumbar Spinal Fusion

PATIENT CLINICAL HISTORY:

This xx-year-old Claimant had low back pain and bilateral hip and leg pain while drilling and lifting on xxxxx. The claimant is status post anterior-posterior L5-S1 fusion 10 years ago.

A lumbar MRI on 10-04-07 noted a L5-S1 lumbar fusion with screw fixation. The metallic artifact compromised the study. A 10-29-07 physician evaluation noted lumbar spine injury, paralumbar “tightness,” lower extremity weakness, and no atrophy. The myelogram dated 11-09-07 noted significant degenerative changes at the L5-S1 level and degenerative disc disease at L4-5. There is a minimal canal stenosis and foraminal narrowing reported.

The physician progress note of 11-12-07 indicated that there was a canal stenosis from L2-L4. The Reviewer noted that this was not reported on the imaging study. There is severe low back pain, and it was noted that the claimant could not return to work. The physician note also stated that an epidural steroid injection was planned, and the pre-authorization request is for a laminectomy and fusion with custom back brace.

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

The Reviewer commented that the MRI clearly does not note any changes at L3-4 that what would require surgical intervention. The changes noted at L4-5 are degenerative changes and in line with ODG, this is not amenable to fusion in the workers compensation setting. In addition, the ODG notes fusion is “Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurological dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis, or frank neurogenic compromise.” As previously noted in the records, there have not been any conservative measures. In the opinion of the Reviewer, based on medical documentation, there is no medical evidence of instability, infection, or fracture. Therefore, the requested surgical procedure with one-day hospital stay is not medically necessary for this claimant.

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)**