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Notice of Independent Review Decision

DATE OF REVIEW: 04-29-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar fusion and instrumentation L4-S1

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	996.79 724.4 724.02	63047 22612 22840 22842	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination dated 03-12-08 and 04-01-08
Workers' Compensation Pre-authorization Request
Medical notes dated 02-21-07, 03-26-07, 04-02-07, 05-02-07, 06-04-07, 06-11-07,
08-13-07, 10-08-07, 11-28-07, 01-07-08, 02-11-08, 03-05-08
Operative report 11-13-07
Lumbar Myelogram dated 09-12-07
MRI lumbar spine with and without contrast dated 12-06-07, 05-18-07, 01-28-08
Official Disability Guidelines (ODG) back protocol, Patient Selection Criteria for
Lumbar Spinal Fusion

PATIENT CLINICAL HISTORY:

An MRI of the lumbar spine noted a disc herniation at the L5-S1 level with multiple level degenerative changes. On 02-06-07, the claimant underwent a two level lumbar laminectomy and discectomy. Post-operatively the claimant did reasonably well. Subsequent to this evaluation, the claimant underwent physical therapy and continued to have some difficulty with ambulation.

A repeat MRI noted the post-operative changes and the pre-existing degenerative pathology. Epidural steroid injections were done, as well as additional physical therapy. The complaints continued, and a lumbar myelogram was obtained. Scar tissue, disc desiccation, and facet arthrosis were noted. A second surgery to remove the scar tissue was suggested and completed on 11-13-07. Within months, the pain complaints returned.

A 01-25-08 MRI noted repeat diffuse disc bulging and a recurrence of the scar formation. A pin management consultation was sought. The claimant was then evaluated by a specialist, who reported a post-laminectomy syndrome, spinal stenosis, lumbar radiculopathy, and degenerative disc disease of the lumbar spine. This was followed with a request for a lumbar surgery with 3-day inpatient stay. The actual surgery was not certified.

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

The ODG do not mention the length of hospital stay for a fusion procedure. Moreover, the ODG clearly do not support the use of a fusion procedure in the workers' compensation unless there are specific criteria met. Based on the clinical data presented, these criteria are not met and the surgery itself is not indicated. (Patient Selection Criteria for Lumbar Spinal Fusion: For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: 1) Neural Arch Defect – Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. 2) Segmental Instability (objectively demonstrable) – Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy.) Therefore, in the opinion of the Reviewer, the surgery itself is not indicated, and then there is no indication for the hospitalization.

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)