

Notice of Independent Review Decision

DATE OF REVIEW: 05-03-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right L5 nerve root decompression, posterior spinal fusion L4-S1, pedicle screws, anterior spinal fusion L4-S1, Synthes CCALIF, AOL screws with 2 day 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	722.10 724.4	22612 22614 22842 63047 63048 63090 63091 22558 22845	Overturn

				22851	
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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Determination dated, 03-17-08 and 04-08-08
Activity Notes
Surgery Pre-Authorization Estimated Date of Service: April 2 to May 2, 2008
Medical notes dated, 07-24-04, 08-03-04, 08-18-04, 09-03-04, 09-08-04, 10-04-04, 10-19-04, 12-13-04, 02-11-05, 12-03-07, 12-19-07, 03-06-08, 01-17-08,
Physical Therapy Progress Report dated, 10-18-04
Telephone communication noted dated, 02-17-05
CT Scan Lumbar Spine Post Discogram dated, 02-18-08
Operative Note dated, 02-28-08
Motor Nerve Conduction Study dated, 08-14-07
Diagnostic Imaging Report dated, 07-11-07
MRI lumbar spine dated, 06-13-06 and 08-04-04
Radiology Report (outside films) dated, 07-24-04
Functional Abilities Evaluation dated, 08-27-07
Official Disability Guidelines (ODG) –Treatment in Worker’s Comp 2007 (Low Back – Fusion)

PATIENT CLINICAL HISTORY:

According to the information received, the claimant was injured on xx/xx/xx while lifting some pipes. The claimant complained of back pain. A laminectomy / discectomy L5-S1 level was performed on 12-2006. Apparently there was some relief for about 5-6 months and pain recurred. The claimant complained of progressive back pain and right lower extremity pain. A CT myelogram – lumbar spine was done on 7-2007 reported as normal. An MRI – lumbar spine on 6/2006 was also done. EMG / NCV studies on 8-2007 reported presence of mild sub-acute L5 radiculopathy of the right and left. The claimant received 2 steroid injections with some relief. Also received physical therapy and medications such as muscle relaxant and anti-inflammatory.

The medical note of 3-6-08 stated that a physician performed an awake, pressured-controlled, pain provocative discogram study and further validated the study by establishing a control (L3-L4 disc space). It was reported that the L4-L5 disc was symptomatic and L5-S1 (site of prior surgery) was reported to mildly symptomatic. Post discogram CT study showed diffuse annular tearing at the L4-L5 level and evidence of diffuse annular degeneration and tearing at the L5-S1 level.

The note further stated that since failure of conservative treatment, the claimant required surgical intervention. The request for spinal surgery was non-certified.

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

In the opinion of the Reviewer, the proposed surgical procedure should be authorized because the patient's condition satisfies ODG Guidelines for spinal fusion according to the statement "Pre-Operative Surgical Indications Recommended" in the "Fusion (spinal)" section of the "ODG TWC Low Back." The Reviewer commented that the patient has a classical combination of instability as a result of facet arthrosis syndrome that has failed all conservative therapy.

According to the Reviewer, the spinal surgery is therefore medically necessary and with this procedure, a 2-day stay hospital stay is minimal (and reasonable). ODG-TWC ICD 722.10 Intervertebral disc disorders, indicate average length of hospital stay for requested procedure as 2.5 days.

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)