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Notice of Independent Review Decision

DATE OF REVIEW: 10/3//2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar re-exploration with lumbar decompression and foraminotomy with removal of bone fragment, exploration of spinal fusion and possible re-implementation of spinal instrumentation at L4-5 & L5-S1, with 2 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, and fellowship-trained in surgery of the spine

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	95937	Overturned
		Prospective	724.4	RC111	Overturned
		Prospective	724.2	63048	Overturned
		Prospective	724.10	20902	Overturned
		Prospective	724.10	95920	Overturned
		Prospective	724.10	22830	Overturned

		Prospective	724.10	22612	Overtured
		Prospective	724.10	63047	Overtured

PATIENT CLINICAL HISTORY:

The claimant is a xx-year-old male who suffered work-related injury from a motor vehicle accident in xx/xx. He had continuing low back pain for which he underwent L4-5 discectomy in August 2006 and then L4-S1 fusion in August 2007. The patient has participated in a pain management program and is on medication for the pain as well as for depression. He has pain in his low back radiating into his left hip and leg with numbness and tingling.

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

In the Reviewer’s opinion, the documentation supports that the lumbar spine surgery being requested for this patient is medically necessary. The Reviewer explained that the patient has severe spinal stenosis with both combination facet arthrosis and instability, as well as severe radiculopathy of his lumbar spine. The Reviewer agreed with the treating physicians in this case that this evidence of both radiculopathy and spinal stenosis cannot be treated non-surgically. In the Reviewer’s opinion, all of the ODG criteria for the requested surgery have been met. The Reviewer felt that, given the severity of the objective findings in this case, the surgery should be authorized as requested without further delay for this patient who is also suffering from depression due to chronic pain.

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)