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Notice of Independent Review Decision

DATE OF REVIEW: 9/8/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal Lumbar Interbody Fusion

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	22630	Overturned

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Preauthorization Report dated 6/26/08
Reconsideration Preauthorization Report dated 8/23/08
nMedical notes dated 4/8/08, 4/22/08, 5/14/08, 7/22/08, 7/30/08
MRI Lumbar Spine dated 3/20/08
MRI Lumbar Spine 2nd opinion dated 4/6/08
MRI Cervical Spine dated 4/11/08
X-ray Lumbar Spine dated 4/11/08
Psychiatric evaluation dated 6/18/08
Correspondence regarding billing, including Health Plan claim form dated
6/18/08, Explanation of Benefits dated 7/3/08
Official Disability Guidelines cited but not provided

PATIENT CLINICAL HISTORY:

The claimant is a xx-year-old female who suffered a work-related injury in xx/xx when an eighteen-wheeler truck hit the school bus she was in from behind. The patient has had low back pain and ambulation problems after the injury. She has low back pain and her back pain while walking results in a limp on the right side. She has had physical therapy and conservative care, but her symptoms have not improved. Imaging tests showed grade 1 spondylolisthesis at L5-S1.

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

In the Reviewer's opinion, the requested surgery (transforaminal lumbar interbody fusion) is medically indicated necessary for this patient, and meets the criteria as outlined in the Official Disability Guidelines TWC Low Back –Lumbar & Thoracic – Fusion (spinal). The Reviewer noted that the patient suffers with persistent neurologic pain, as well as lumbar segmental instability at L5/S1. The Reviewer further noted that it is highly unlikely to have bilateral L5 spondylosis without having painful instability at L5/S1. It has been over 6 months since her injury, all conservative therapy has failed, and there are no other legitimate treatment options available at this point.

The Reviewer explained that the patient's pain, physical examination, and radiographic studies all show a combination instability/facet arthrosis syndrome. The Reviewer noted that this patient has instability with L5/S1 spondylolisthesis, and all criteria for ODG fusion for instability have been met. In the Reviewer's opinion, the requested surgery should be authorized as soon as possible.

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)