

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 04/25/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Exploratory lumbar laminectomy, L4/L5, L5/S1 posterior lumbar interbody fusion with pedicle screw fixation

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the spine-injured patient

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.10	95937		Prosp.				xx-xx-		xx-xx-

							xx		xx
722.10	95920		<i>Prosp.</i>						
722.10	22840		<i>Prosp.</i>						
722.10	22851		<i>Prosp.</i>						
722.10	76001		<i>Prosp.</i>						
722.10	20938		<i>Prosp.</i>						

INFORMATION PROVIDED FOR REVIEW:

1. 1. Case assignment.
2. Letters of denial 04/03 & 03/25/09, including criteria used in the denial, and correspondence 04/10/09
3. Orthopedic surgeon evaluation 03/19/09
4. Radiology reports 12/08/08 & 11/11/08
5. H&P 11/24/08 and surgery follow up evaluation 12/15/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This male suffers with lumbar pain and left lower extremity pain subsequent to an injury that occurred on xx-xx-xx. He has a past history of lumbar surgery in 1991. On xx-xx-xx he suffered a twisting, straining injury to his lumbar spine while attempting to control a loaded wheelbarrow. His physical findings reveal only a positive straight leg raising test on the left side, negative on the right. There are no other objective physical findings. The radiographic findings suggest degenerative disc disease with lumbar spondylosis. There is no radiographic evidence of instability.

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

There are no documented objective physical findings to suggest compression of nerve roots. The symptoms are radicular, and the positive straight leg raising test is suggestive of a radiculopathy involving the nerve roots on the left side. However, there is no specific nerve root identified as compressed. There has been no medical

treatment documented and no psychological evaluation is present. The criteria necessary to justify the performance of an exploratory lumbar laminectomy at L4/L5 and a posterior lumbar interbody fusion at L5/S1 with pedicle screw fixation have not been met. The prior denial of this preauthorization request was appropriate. The reconsideration denial was appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 national accepted medical literature (provide a description).

_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)