

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 02/23/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior/posterior lumbar interbody fusion at L4/L5 and L5/S1 for medical necessity.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
722.10	20930		Prosp.						Upheld
722.10	20936		Prosp.						Upheld
722.10	22558		Prosp.						Upheld
722.10	63090		Prosp.						Upheld
722.10	22842		Prosp.						Upheld
722.10	22840		Prosp.						Upheld
722.10	22612		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial, 01/15/09 and 01/26/09 including criteria used in the denial
3. IRO summary, 02/03/09
4. Pain management treatment notes, 10/02/07 through 01/20/09
5. Surveillance report, 01/16/09
6. Case review, 01/23/09
7. Orthopedic consultation, 12/19/07, 01/15/08, and 01/28/08
8. Neurosurgical consultation, 09/17/08 and additional exams 09/15/08 and 09/17/08
9. Electrodiagnostic results, 01/25/08
10. Radiology reports, 10/23/07 and 11/02/07
11. Examination and evaluation (unidentified specialty), 03/21/08
12. Hospitalization documentation for the following admissions: 09/29/07, 11/06/07, 12/04/07, 12/18/07, 04/14/08, 05/21/08, 06/20/08, 07/10/08, 07/24/08, 07/25/08, 11/28/08, and 12/18/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient had an injury to the lower back and was said to have disc herniations. The patient has failed conservative care, and L4/L5 and L5/S1 interbody fusion anterior/posterior has been recommended by the patient's treating neurosurgeon. This has been denied by the insurance company as medically unnecessary.

The patient had a discogram with equivocal findings and reports of concordant pain those two levels. The patient failed extensive treatment including pain management, multiple injections, physical therapy and medical management. X-rays of the patient's lumbar spine revealed degenerative narrowing at L5/S1. An MRI scan showed 3-mm disc protrusion at L5/S1 with minimal neural foraminal compromise and small annular tear at L4/L5 and disc protrusion. The patient saw three (3) spine surgeons who have recommended various types of procedures including facet injections, lumbar disc replacement, and fusion.

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

In reviewing this patient's extensive medical records, there is a lot of evidence of symptom magnification. I do not believe there has been a thorough enough evaluation and treatment of confounding psychological

factors in this case. Although the patient may benefit from a lumbar spine fusion in the future, I do not believe that the patient is psychologically stable at this point for lumbar disc fusion. In addition, the medical records are equivocal with regard to the appropriate identification of this patient's pain generators. At this time, based on medical necessity and evidence-based medicine, as well as ODG Guidelines, the patient is not a candidate for anterior/posterior lumbar interbody fusion at L4/L5 and L5/S1.

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 judgment, 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.)