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Notice of Independent Review Decision

DATE OF REVIEW: 1/9/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360 Fusion Lumbar L5-S1

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 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	722.52	63090	Upheld
		Prospective	722.52	22558	Upheld
		Prospective	722.52	22851	Upheld
		Prospective	722.52	20931	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, references for screening criteria, letters and requests for reconsideration, request for review by an independent review organization, and prior notice of independent review decision.

Employers First Report Of Injury or Illness/Associate Statement dated xx/xx/xx
Notification of Suspension of Indemnity Benefit Payment dated 8/23/07

Practitioner/Physician/Consultation notes dated 12/15/08, 11/10/08, 10/29/08, 8/29/08, 7/18/08, 5/8/08, 4/24/08, 4/9/08, 4/11/08, 4/4/08, 2/27/08, 1/16/08, 11/27/07, 11/7/07, 10/10/07, 8/22/07

Patient Office Visit Reports/Exercise Sheets dated 7/24/07, 7/25/07, 7/26/07, 7/27/07, 7/30/07, 7/31/07, 8/20/07, 8/23/07, 8/27/06, 8/28/07, 8/29/07, 8/30/07, 9/6/07, 9/7/07, 9/10/07, 9/11/07, 9/12/07, 9/13/07, 2/6/08, 3/24/08, 7/29/08

Research Company Assignment dated 9/29/08

X-ray report dated 2/27/08, 12/26/07, 8/6/07,

Procedure report dated 12/26/07, 10/23/07, 9/27/07

Job Offer dated 2/7/08

Official Disability Guidelines cited Low Back-Lumbar & Thoracic (Acute & Chronic)
Lumbar Fusion, Discography

PATIENT CLINICAL HISTORY:

This xx-year-old claimant sustained a low back injury on xx/xx/xx, while lifting car batteries at work. The claimant is status post laminectomy/discectomy at L5-S1 level in 2003-2004 and did well until xx/xx/xx. Treatment has included physical therapy, epidural steroid injections, and medications. According to a consultation note of 2/27/08, the claimant sustained another injury when a customer's truck door hit his back. The patient continues to have low back and left lower extremity pain.

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

Per the Reviewer, the treatment included facet injections and the focus of treatment appears to be the facet joints. Later, a physician felt this to be a radiculopathy. Repeat imaging studies noted a disc lesion. It is noted that maximum medical improvement had not been reached. In the professional opinion of the Reviewer, based on the data presented and after reviewing the specific parameters noted in the ODG, there is no basis to overturn the determination made.

**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)

