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Notice of Independent Review Decision

DATE OF REVIEW: 1/13/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L3-4, L4-5, L5-S1 Anterior lumbar interbody fusion (ALIF) with femoral and iliac allograft and internal fixation; L4-L5 laminectomies foraminotomies; L3-S1 posterior spinal fusion with right iliac crest bone graft (ICBG) and internal fixation with 4 day inpatient 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 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	22845	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 1/31/07, 2/7/07, 2/21/07 (with procedure note), 3/7/07 (with procedure note), 3/14/07 (with procedure note), 4/4/07, 8/21/08

Physical Therapy evaluation dated 12/9/08

X-ray reports dated 7/30/08

Official Disability Guidelines cited (Low Back Chapter, Criteria for Lumbar fusion) but not provided

PATIENT CLINICAL HISTORY:

According to the information provided, this claimant with a prior history of back and leg pain, and employed as a , had his pain exacerbated on xx/xx/xx after a hard landing. Treatment has included epidural steroid injections and medications. The claimant continues to complain of low back pain and leg pain.

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

In the Reviewer's opinion, the requested procedure and 4 day inpatient stay should be authorized as requested. This claimant has evidence of multilevel L3-S1 instability and combination instability/facet arthrosis syndrome. It was noted that the claimant has severe radiculopathy and severe posttraumatic degenerative disc pain. The Reviewer noted that the claimant has failed all appropriate conservative care. Therefore, the purposed surgery (360 fusion with instrumentation and autogenous iliac bone grafting) for this multilevel case is appropriate.

In conclusion, this patient has had all appropriate preoperative workup, including CT myelogram. In addition, this claimant's clinical course and history (appropriate conservative care and over two years of severe pain) qualifies this patient for the requested procedure pursuant to the Official Disability Guidelines.

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)**