



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 03/20/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior and posterior discectomy with fusion at L5/S1.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of the patient suffering low back pain and discogenic back pain

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
			<i>Prosp.</i>						<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. Case assignment
2. Letters of denial, 02/09/09 and 02/20/09 including criteria used for denial
3. Orthopedic treating doctor evaluation and office visits 02/01/07 through 10/10/08 and correspondence 01/27/09
4. Therapy and Diagnostics documentation, 03/05/07 through 12/15/08
5. Radiology reports, 02/01/07, 02/13/07, and 02/14/07
6. Enhanced interpretive report, 02/26/08
7. Psychiatric evaluation, 04/08/08
8. Pre-surgery consultation and behavioral assessment, 09/24/08
9. Evaluation, 02/09/09
10. Designated Doctor Evaluation, 01/09/09
11. Attorney's correspondence, 12/30/08
12. Operative reports, 04/24/07 and 08/21/07
13. Work status reports, 02/01/07 through 05/13/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This female was the passenger on a bus struck by a train on xx/xx/xx. She has suffered chronic low back pain subsequent to injuries sustained in the motor vehicle/train accident. Initially she suffered some right knee sprain injuries, which required treatment and resolved. Her low back pain has been treated with physical therapy, medications, activity modifications, and epidural steroid injections. An MRI scan on 02/13/07 revealed suggestions of an intervertebral disc protrusion at the level of L5/S1 with both left and right S1 neural foraminal compromise. A discogram performed revealed concordant pain at L5/S1. The

diagnosis has been discogenic low back pain. Anterior and posterior discectomy and fusion at the level of L5/S1 has been recommended. It has been denied, reconsidered, and denied.

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

This patient has no medical documentation of instability of any motion segment in the lumbosacral spine region. There is no documented evidence of progressive neurological compromise. Confounding psychological issues evidenced in the initial psychological evaluation have not been specifically addressed. The results of lumbar spine fusion for mechanical low back pain without evidence of instability or specific radiculopathy performed under the Workers' Compensation system have a lower than expected outcome result when compared to similar procedures performed in other circumstances. The medical necessity and likelihood of an acceptable result are not well established in the medical record documentation provided when the documentation is compared with criteria established in the ODG 2009 Low Back Pain Chapter, Fusion Spinal passage.

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