

Notice of Independent Review Decision

DATE OF REVIEW: 03/29/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique); 01/22/09 to 01/24/09.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation of and treatment of patients suffering spinal problems

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
722.52	LOS		Prosp.						Upheld
722.52	22612		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

- Case assignment
- Letters of denial, 01/23/09 and 02/11/09 including criteria used in denial
- Preauthorization requests, 01/21/09 and 02/09/09
- Physician preauthorization requests, 01/22/09 and 02/12/09
- Orthopedic surgeon's office notes 03/14/06 through 12/23/08, twenty visits
- Evaluation, 09/05/08
- PPE, 08/16/07
- Physical therapy progress notes, 06/02/06 through 08/01/06
- Psychiatric evaluation, 05/05/06
- Psychological evaluation, 03/25/08
- Steroid injections, 07/20/06 and 10/03/06
- Radiology reports, 12/22/08, 08/17/08, 04/10/06, and 08/01/05

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This female suffered the onset of low back pain and leg pain after lifting heavy boxes on xx/xx/xx. She has had numerous physician evaluations and multiple radiologic imaging studies. She has multiple level spondylosis and degenerative disc disease evident on more than one MRI scan. She has mild chronic L5 radiculopathy on EMG studies. Neurologic evaluation has been inconsistent. She has had multiple methods of treatment including physical therapy, activity modifications, medications, and epidural steroid injections. Her gait is antalgic. There are sensory changes in the L5 dermatome on the right side, and negative straight leg raising bilaterally most recently. On 09/19/08 a lumbar discogram was performed, confirming multiple level degenerative disc disease. There was incomplete concordant pain at L3/L4 and

L4/L5 with no pain at L5/S1. A discectomy decompression 360-degree fusion at L4/L5 and L5/S1 has been recommended by the provider.

She has been recommended to have surgical procedures on more than one occasion. The denial letters state that the requested service is posterolateral and posterior fusion with two-day length of stay.

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

It would appear that this patient has had extensive treatment on a non-operative basis for degenerative disc disease. It does not appear to be radiculopathy. There does not appear to be specific neural encroachment producing neural element compression. The psychological evaluations have been inconsistent, suggesting the patient does suffer from anxiety and depression. Psychotherapy has been recommended, and its accomplishment has not been well documented. At this time, the denial of this procedure for medical necessity is 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 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:
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)