



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 3/19/09

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Anterior/Posterior Discectomy with Fusion L4-L5, 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 Orthopedic 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		22845, 63091, 63090, 69990, 62351, 20974, 20936, 22614, 22612, 22842, 63047, 22585	Overturned
		Prospective	839.2	22558	Overturned
		Prospective	722.10	22851	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.

Surgery Reservation Sheet

Consult notes dated 2/11/09, 1/5/07, 8/30/06

Re-Evaluation note dated 12/3/08

Physician notes dated 7/17/07, 3/27/07, 10/31/06,

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X-ray reports Lumbar (undated), 11/28/06, 9/8/06, 8/16/06  
Computerized Muscle Testing and Range of Motion report dated 2/11/09  
Nerve Conduction/EMG report dated 6/17/05  
Operative notes dated 10/6/06, 5/12/05, 4/28/05, 4/14/05, 3/31/05  
Official Disability Guidelines provided–Fusion (spinal)

**PATIENT CLINICAL HISTORY:**

This claimant sustained an injury to the lumbar spine on xx/xx/xx while lifting an executive chair at work. Prior treatment included physical therapy, lumbar epidural injections (x3), and a sacroiliac injection. Due to the claimant's complaints of continued back pain with pain radiating down the left lower extremity, surgery was recommended.

**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 should be authorized as requested. Per the Reviewer, this claimant has severe pain and instability of the lumbo-sacral spine, and combination instability/facet arthrosis syndrome. This is secondary to failure of both the L4/5 and L5/S1 annulus. The claimant has clear objective evidence of both motor and sensory deficits and has severe progressive objective radiculopathy at both of the proposed surgical levels.

The Reviewer noted that the claimant has failed all appropriate conservative treatment, including epidural injections. According to the Reviewer, the claimant had no evidence of psychological disorders, therefore, this is not a required exam prior to the proposed surgery.

In conclusion, this claimant's clinical course and history (appropriate conservative care and over 4 years of severe pain) qualifies this claimant 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**

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- 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)**