



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/28/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal of spinal lamina, lumbar spine fusion, insertion of spine fixation, application of spine prosthetic device, spinal bone graft, local injection of the foramen, epidural lumbosacral

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering spine problems and spine injury

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.4	63047		Prosp.						Upheld
722.10	22612		Prosp.						Upheld
	22630		Prosp.						Upheld
	22840		Prosp.						Upheld
	22851		Prosp.						Upheld
	20936		Prosp.						Upheld
	64483		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. IRI forms
2. TDI referral forms
3. Certification of independence of the reviewer
4. SRS letters of denial, 01/19/10, 12/29/09, 10/14/09, 08/26/09
5. Surgery preauthorization forms, 12/16/09, 10/08/09, and 08/19/09
6. Orthopedic office notes and progress notes between 01/14/09 and 03/02/10
7. Operative reports for epidural steroid injection, 03/09/09 and 04/24/09
8. MRI scan of the lumbar spine, 01/23/09
9. Designated Doctor Evaluation for MMI and return to work status, 07/16/09
10. TWCC form 73, 07/23/09
11. Psych evaluation, 09/30/09
12. Designated Doctor appointment letters, 07/07/09
13. Functional Capacity Evaluation, 07/07/09
14. Spine surgeon office visits, 08/11/09 through 12/11/09

15. Lumbar evaluation, 04/08/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a female who suffered multiple injuries in a fall occurring on xx/xx/xx. Her initial injuries were felt to be multiple contusions. She developed low back pain and periodically suffered lower extremity pain. She has had intermittent symptoms of lower extremity radiating pain, most commonly on the right but periodically on the lower extremities bilaterally. Her straight leg raising tests have been intermittently positive. There have been no specific motor or sensory losses. Deep tendon reflexes are described only as diminished knee jerks. She underwent an MRI scan of the lumbar spines on 01/23/09, revealing facet hypertrophy at the level of L5/S1 with impingement of exiting nerve roots bilaterally. She has been treated with medications including non-steroidal, anti-inflammatory medications, activity modifications, and epidural steroid injections. She has had limited relief of symptoms. Currently the recommendation is for a decompression procedure at the level of L5/S1 with both anterior and posterior instrumentation fusion. The recommendation for this surgical procedure has been considered on a number of occasions and has been denied. Reconsiderations have occurred, and the denials have been upheld.

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

It would appear that this patient's principle symptom is pain unrelieved by medications, activity modifications, and epidural steroid injections. There has been no investigation of potential instability of motion segment L5/S1. There has been no investigation to determine the full extent of potential pain generating sites. As such, at this time the patient is not a suitable candidate for a decompression procedure and extensive 360-degree fusion procedure.

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