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Notice of Independent Review Decision  
**IRO REVIEWER REPORT**

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**DATE OF REVIEW:** 8/12/10

**IRO CASE #:**                      **NAME:**

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

Determine the appropriateness of the previously denied request for inpatient one day (LOS) length of stay, right L4-L5 discectomy with interlaminar fusion (63047, 22612, 22840) and a TLSO brace and bone growth stimulator.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

Texas licensed Neurological Surgeon

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Upheld                | (Agree)                          |
| <input checked="" type="checkbox"/> Overturned | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned  | (Agree in part/Disagree in part) |

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for inpatient one day (LOS) length of stay, right L4-L5 discectomy, with interlaminar fusion (63047, 22612, 22840) and a TLSO brace and bone growth stimulator.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- UR Findings dated 7/20/10, 6/16/10.
- Follow Up dated 6/4/10, 3/5/10, 1/22/10, 12/30/09, 10/28/09, 10/2/09, 8/26/09, 6/24/09.
- Lumbar MRI dated 2/2/10, 5/12/09.
- Operative Report dated 1/8/98, 10/17/96.
- Article (date unspecified).

**PATIENT CLINICAL HISTORY (SUMMARY):**

Age:

**Gender: Male**  
**Date of Injury: xx/xx/xx**  
**Mechanism of Injury: Unknown**

**Diagnosis: Lumbago 724.2**

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

This male was injured on xx/xx/xx due to an unknown mechanism. He was status post L5-S1 fusion, as well as a re-do fusion at L5-S1 for a nonunion. He complained of right leg pain. His neurological examination revealed 4+/5 right dorsiflexion and decreased sensation in the right L5 distribution. He had undergone an epidural steroid injection, non-steroidal anti-inflammatory drugs, pain medications, and physical therapy. An MRI of the lumbar spine on 02/02/10 revealed a broad-based protrusion at L4-5 with extrusion to the right, which compressed the right-sided thecal sac and potentially affected the traversing right L5 nerve root. The provider was requesting a right lumbar L4-5 discectomy with interlaminar fusion, with CPT 63047, 22612, 22840, a TLSO brace, a bone growth stimulator and a one day inpatient LOS. The right lumbar L4-5 discectomy, with CPT 63047, 22612, 22840, a TLSO brace, and a bone growth stimulator, is medically necessary. The claimant has adjacent level degeneration to his prior fusion. He is symptomatic from this with neurologic deficits, despite conservative measures. The treatment for this is decompression and fusion. Since he has already undergone a fusion and the pathology is a direct result of that prior fusion, a psychological evaluation is not needed. According to the ODG, "All pain generators are identified and treated" prior to a lumbar fusion and there should be an "MRI demonstrating disc pathology." The pain generator is at L4-5 and there is an MRI that shows the disc pathology to correlate, which is adjacent to the prior fusion. The aforementioned CPT codes are appropriate for this procedure. Also according to the ODG, a post-operative fusion back brace is "under study," and this is, by convention, used after a lumbar fusion. Also, a bone growth stimulator for a lumbar fusion is "under study," and an indication for its use is "one or more previous failed spinal fusion(s)." The claimant has a prior nonunion at L5-S1. Therefore, he fulfills this criterion, and the bone growth stimulator is, therefore, medically necessary. A one-day LOS is well within the ODG criteria for fusion of four to six days.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.  
Low Back – Lumbar & Thoracic (Acute & Chronic)
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).