

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed PISF/PLIF L5-S1 with LOS 3 days (22612, 22630, 22840, 22851, 20936) with LSO brace (63047)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	22612, 22630, 22840, 22851, 20936, 63047		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-20 pages

Respondent records- a total of 145 pages of records received to include but not limited to: records 8.17.09-4.13.10; Lumbar Myelogram, no date shown; Lumbar median branch block, no date shown; Lumbosacral selective nerve root block, no date shown, report 1.9.09; MRI L-spine 10.24.08, 1.5.10; Cervical CT with 3 D 10.2.09; P.C. report 11.18.09; records 10.6.08-6.30.09; RME 4.7.09, 4.13.09; note Dr. 11.6.08

Requestor records- a total of 43 pages of records received to include but not limited to: records 8.17.09-4.13.10; Lumbar Myelogram, no date shown; Lumbar median branch block, no date shown; Lumbosacral selective nerve root block, no date shown, report 1.9.09; MRI L-spine 10.24.08, 1.5.10; Cervical CT with 3 D 10.2.09; P.C. report 11.18.09; records 4.15.09-6.30.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the prior determinations of non-certification. Dr. noted that there was no electrodiagnostic evidence of radiculopathy, pars defect, instability, infection or fracture. Dr. noted the disc lesion, but that the requirements for a lumbar fusion were not met.

After the first non-certification, Dr. prepared a note indicating that the injured employee had low back pain with right lower extremity symptoms. The only finding on physical examination was a slightly diminished Achilles reflex. The disc lesion was noted to be at the L5-S1 level only. Laminectomy and fusion were again suggested.

The conservative measures performed were reviewed. As was the January 2010 lumbar MRI that noted a 5 mm disc lesion.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines the standards for a lumbar fusion are noted as (As per May 18, 2010):

- (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia.
- (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. ([Andersson, 2000](#)) ([Luers, 2007](#))
- (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. ([Andersson, 2000](#))
- (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature.
- (5) Infection, Tumor or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.
- (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria.

The criteria for a one level lumbar fusion are not met. The disc lesion needs to be addressed only not in the fashion requested.

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
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)