



Notice of Independent Review Decision

DATE OF REVIEW: 6/30/10

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for a **2 level posterior lumbar interbody fusion (PLIF) at L4-5 and L5-S1 with CPT codes 22612-51, 22630, 22842, 22937, 22851, 22614, 22632, 69990, and a 3-day inpatient stay.**

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:

- Upheld (Agree)
- Overturned (Disagree)
- 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 **2 level posterior lumbar interbody fusion (PLIF) at L4-5 and L5-S1 with CPT codes 22612-51, 22630, 22842, 22937, 22851, 22614, 22632, 69990, and a 3-day inpatient stay.**

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 6/14/10.
- IRO Request Form dated 6/11/10.
- Request for Review by an Independent Review Organization dated 6/10/10.
- Request for Reconsideration Letter dated 5/25/10.
- Request for Authorization Letter dated 5/6/10.
- Medical Dispute Resolution Request Letter dated 5/30/10.
- Workers Compensation Pre-Certification Request dated 5/5/10.
- Letter of Reconsideration and Appeal dated 5/10/10.
- Pre-Surgical Psychological Evaluation dated 5/3/10.
- Follow-Up Visit dated 4/21/10, 3/17/10.
- Referral Letter dated 2/17/10.
- Office Visit dated 4/15/10, 4/12/10, 11/18/09, 9/18/09, 9/11/09.
- Patient Report/Letter dated 1/5/10.
- Initial Examination dated 12/28/09.
- Emergency Department Medical Record dated 9/9/09.
- Lumbar Spine MR dated 3/10/10, 9/15/09.
- Lumbar Spine CT dated 9/9/09.
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PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Heavy lifting

Diagnosis: Lumbago

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

This female had a date of injury of xx/xx/xx. The mechanism of injury was heavy lifting. She was diagnosed with lumbosacral neuritis with small disc protrusions. She complained of persistent and intractable back and right leg pain. She had undergone medications, chiropractic therapy, and epidural steroid injections (ESI). Her neurological evaluation revealed absent knee and ankle jerks. An MRI of the lumbar spine, dated 3/10/10, revealed shallow disc protrusions with annular tears at L4-5 and L5-S1 with narrowing of the superior left L5-S1 foramen related to a prior fracture of the superior facet of S1. An Agreed Medical Evaluation (AME), dated 4/5/10, noted bilateral extensor hallucis longus (EHL) and quadriceps weakness with decreased sensation in the right lower extremity. A lumbar discogram, dated 4/12/10, revealed concordant pain at L4-5 and L5-S1. L3-4 served as a negative control. A presurgical psychological evaluation, dated 5/3/10, found no contraindications to surgery. The provider is requesting a PLIF at L4-5 and L5-S1 with CPT codes 22612-51, 22630, 22842, 22937, 22851, 22614, 22632, 69990 and a 3-day inpatient stay. The proposed surgery is medically necessary. The claimant had failed

reasonable conservative measures for her pain. According to the ODG, "Low Back" chapter, "All pain generators should be identified and treated" prior to a lumbar fusion. It also states, "Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction." Based on the neuroimaging and discography reports, the pain generators appear to be L4-5 and L5-S1. A preoperative psychological evaluation has been done and the patient is a non-smoker. Her condition meets the ODG criteria for a lumbar fusion. The associated CPT codes are appropriate for the intended procedure. A 3-day length of stay is also appropriate for a two-level lumbar fusion.

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, Fusion.**
- 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).