

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 04/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Re-do decompression at L4/L5, intraoperative evaluation of fusion if necessary, augmentation of the fusion if necessary, removal of facet screw.

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 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>
722.83	63042		Prosp.						Upheld
722.83	22830		Prosp.						Upheld
722.83	22612		Prosp.						Upheld
722.83	22852		Prosp.						Upheld
722.83	99221		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment..
3. Letters of denial 03/17 & 02/25/10, including criteria used in the denial and extensive UR documentation..
4. Spine surgeon's evaluation and follow up 01/23/09 – 09/29/09.
5. Treating doctor's evaluations and follow up 06/22/09 – 02/26/10.
6. Psychologist's evaluation and progress notes 01/29/09 – 05/13/09.
7. Psychological evaluation 12/02/09 & 12/31/09.

NOTE: Additional clinical information was made available to the reviewer upon request from the period of mid-2009 back to the date of injury 04/19/05.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a female who suffered a straining injury to the lumbar spine on xx/xx/xx. She suffered low back pain and lower extremity pain, more into the right leg than the left. On 02/27/07 she underwent a decompression of the L4/L5 for spinal stenosis and herniated nucleus pulposus on the right side. On 06/10/08 an anterior lumbar interbody fusion at L4/L5 and facet screw fixation posteriorly were performed.

The patient has had persistent pain and has been treated in a pain management program. She has undergone a number of diagnostic studies including MRI scans of the lumbar spine and CT myelogram. The most current imaging studies failed to reveal evidence of compressive neuropathy, and the fusion mass appears to have developed. There are no studies which demonstrate instability. The physical findings failed to reveal objective findings of radiculopathy. A recommendation for re-do decompression at L4/L5 and intraoperative evaluation of the fusion with augmentation of the fusion mass, if necessary, and removal of the facet screw was recommended. It was considered and denied, reconsidered and denied.

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

The medical records do not support the possibility of that a recurrent compressive radiculopathy has developed. There is no evidence of instability, nor is there any finding to suggest that the facet screws are generating pain. There are no clear indications for a revision surgery, and as such, the conclusion must be that the prior denials were appropriate and should be upheld.

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

- 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.)