



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
REVIEWER'S REPORT

DATE OF REVIEW: 09/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4/L5/S1 lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, and implantation of bone growth stimulator

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

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>
722.10	63042		Prosp.	1					Upheld
722.10	LOS		Prosp.	2					Upheld
722.10	63044		Prosp.	1					Upheld
722.10	69990		Prosp.	1					Upheld
722.10	22612		Prosp.	1					Upheld
722.10	20938		Prosp.	1					Upheld
722.10	22842		Prosp.	1					Upheld
722.10	20975		Prosp.	1					Upheld
722.10	63685		Prosp.	1					Upheld
722.10	22325		Prosp.	1					Upheld
722.10	22852		Prosp.	1					Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Independent Review forms and memos.
2. TDI case assignment.
3. Letters of denial 08/06/10 & 08/10/10, including criteria used in the denial.
4. Evaluations and follow up of treating doctor 07/21/09 – 07/20/10 (8 visits).
5. Spine surgeon's follow up visits 03/31/09 & 04/30/09.
6. MRI lumbar spine w/o and with contrast 09/24/09.
7. Operative report 03/14/09.

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8. Pain management procedure note 07/02/10.
9. Prior IRO decision 11/20/09.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a male who sustained an injury on xx/xx/xx. This injury ultimately led to an L4/L5, L5/S1 discectomy and fusion performed on 03/14/09. He had a postoperative MRI scan of the lumbar spine dated 09/24/09 which failed to reveal evidence of pseudoarthrosis at L4/L5 or L5/S1. The patient has had persistent pain. He has periodically suffered pain radiating into his leg, more on the left than on the right. He has had a question raised as the location of a right L5 stress fracture. There is no evidence of instability. There has been some question as to the placement of pars interarticularis and pedicle screws. A hardware block was performed on 07/02/10 from L4 to S1 with some transient relief of symptoms. The patient has a positive Lasegue's test bilaterally. Ankle reflex is decreased on the left. A recommendation has been provided for hardware removal, examination under anesthesia, and extensive revision of the fusion site. This recommendation has been considered and denied, reconsidered and denied.

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

There is no radiographic evidence of pseudoarthrosis. There is no radiographic evidence of instability. CT scan has been recommended; however, it has not been performed. There is no current MRI scan. Decisions are being justified by the appearance of images on an MRI scan performed approximately one year ago.

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.)