



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
REVIEWER'S REPORT

DATE OF REVIEW: 04/10/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy, discectomy @ L4-5, add'l level, microdissection technique, arthrodesis lateral @ L4-5, L5-S1, add'l level, apply spinal prosthetic device, insert spinal fixation device, anterior lumbar arthrodesis, invasive electrical stimulator, implantation of EBI stimulator, reduction of spondylolisthesis lumbar spine, add'l level, add'l level, add'l level inpatient hospitalization 2 days, bone graft.

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 (check only one):

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

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
722.10	63030		Prospective				09/15/10		Upheld
722.10	63035		Prospective				09/15/10		
722.10	69990		Prospective				09/15/10		
722.10	22612		Prospective				09/15/10		
722.10	22614		Prospective				09/15/10		
722.10	22851		Prospective				09/15/10		
722.10	20938		Prospective				09/15/10		
722.10	22842		Prospective				09/15/10		
722.10	22558		Prospective				09/15/10		
722.10	20975		Prospective				09/15/10		
722.10	63685		Prospective				09/15/10		
722.10	22325		Prospective				09/15/10		
722.10	22585		Prospective				09/15/10		
722.10	22328		Prospective				09/15/10		
722.10	99234		Prospective				09/15/10		

INFORMATION PROVIDED FOR REVIEW:

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a female who sustained an injury on xx/xx/xx. The examinee slipped and strained her lumbar spine region. She suffered low back pain and subsequently radiating pain most severely into the left leg. She was evaluated and initially treated for a lumbar strain syndrome. She attended at least three sessions of physical therapy, though documentation of the specific physical therapy sessions is not provided. She initially had some beneficial effect of the physical therapy and medication management. She was also treated with activity modifications. She has had recurrence of severe back pain. Electrodiagnostic studies dated 12/09/10 revealed findings consistent with bilateral L5 radiculopathy. She has had physical findings revealing diminished range of motion of the lumbar spines and deep tendon reflexes in the left lower extremity.

There have been inconsistent physical findings with regard to motor weakness. She has had normal heel walking and toe walking on occasion, and on occasion difficulty with the same maneuver. She has had a reported antalgic limp on the left side. She has been reported to have radiographic evidence of instability at L4/L5 and L5/S1 and facet joint subluxation. However, formal radiographic interpretation reports have not been submitted. The request for surgical preauthorization includes lumbar discectomy and fusion, both anterior and posterior, L4/L5 and L5/S1. There is also a request to preauthorize the use of a spinal prosthetic implant and to reduce subluxation of the lumbar spines. The patient has been a cigarette smoker for a number of years. The request for the surgical procedures has been considered and denied, reconsidered and denied.

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

The request to preauthorize lumbar fusion at two levels does not include adequate documentation of non-operative treatment for this patient's low back and left leg pain. The MRI scan does not document specific nerve root compressive changes. The use of the prosthetic device is specifically not recommended as experimental. The documentation of subluxation and instability at L4/L5 and L5/S1 is not well documented. 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:

- 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.)
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