

Notice of Independent Review Decision

**DATE OF REVIEW: 03/03/2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Inpatient lumbar surgery to include L3, L4, L5, and S1; revision, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, implantation of a bone growth stimulator (EBI); inpatient stay x 2 days; CPT codes 63030, 63035, 22612, 22614, 22861, 20938, 22842, 22558, 20975, 63685-99, 22325, 22328, 99222

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

**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.

Upon independent review, I find that the previous adverse determinations should be upheld.

ODG, Low Back chapter, hospital length of stay, *Official Disability Guidelines*. Treatment and Workers Compensation, 16<sup>th</sup> Edition, 2011 updates, low back

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fusion, bone growth stimulator, length of stay, patient selection criteria for lumbar spinal fusion. Guideline for the patient selection criteria for lumbar spinal fusion followed by the bone growth stimulator and the criteria for use for invasive or noninvasive electrical bone growth stimulators

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records Received: 17 page fax 2/15/11 IRO request, 67 page fax 2/15/11 URA response to disputed services including administrative and medical records, 2 faxes 39 & 32 pages received 2/15/11 Provider response to disputed services including administrative and medical records

Information provided for this review includes previous clinical reviews by an M.D., dated 01/31/11 and an M.D., dated 02/10/11. In addition, there are medical records from the treating physician an M.D., that include office visits notes, most recently from 12/07/10, a psychological assessment by an M.D., from 11/28/10, a nerve conduction velocity/electromyography study performed by an M.D., on 10/08/10, an MRI report from Medical Imaging Center dated 07/30/10, interpreted by an M.D., and another MRI report from Medical Group from 10/16/10, interpreted by an M.D.

There are also chiropractic office and treatment notes by a D.C.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an appeal of a preauthorization request previously denied on two occasions. This patient is a female injured on xx/xx/xx with no specific discussion of the nature of the injury. At that time, she had complaints of back pain and bilateral leg pain, left greater than right. She had initially chiropractic treatment by a D.C., which included chiropractic treatments as well as physical therapy modalities with a diagnosis at that time of lumbar sprain/strain.

Ultimately, the patient sought the care of an M.D. The most recent evaluation by the Dr. is dated 12/07/10. X-rays of the lumbar spine that are dated 06/10/08 showed a 10-mm retrolisthesis and extension at L5-S1 with spondylosis and stenosis, facet subluxation and foraminal stenosis, which corrects in forward flexion. The MRI of the lumbar spine 07/30/10 reveals disk herniation L2-3, L3-4, and L5-S1. Previously mentioned EMG and nerve conduction velocity studies dated 10/08/10 revealed evidence of chronic L4, L5, and S1 radiculopathies bilaterally. The psychological assessment dated 11/18/10 recommended six individual psychotherapy sessions with a diagnosis of anxiety disorder and

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depressive features. The Dr. indicates the patient continues to have back pain and leg pain. He states that the patient does have a history of smoking but has promised to quit at this time and for at least a period of six months following surgery. He stated the patient wished to proceed with surgical intervention.

The Dr. submitted additional information on the x-rays that indicates, "L2-3 within normal limits, anterior column 11 mm; L3-4 anterior column measures 6 mm or a loss of 5 mm with facet subluxation and foraminal stenosis; L4-5 anterior column loss to 8 mm with facet subluxation, lateral recess stenosis; L5-S1 anterior column loss to bone on bone with a loss of 11 mm with facet subluxation and foraminal stenosis."

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Upon independent review, I find that the previous adverse determinations should be upheld.

ODG, Low Back chapter, hospital length of stay, *Official Disability Guidelines*. Treatment and Workers Compensation, 16<sup>th</sup> Edition, 2011 updates, low back fusion, bone growth stimulator, length of stay, patient selection criteria for lumbar spinal fusion

ODG: guideline for the patient selection criteria for lumbar spinal fusion followed by the bone growth stimulator and the criteria for use for invasive or noninvasive electrical bone growth stimulators

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## **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
- 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
- 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)