

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 02/13/11

**IRO CASE #:**

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

Anterior and posterior lumbar fusion with instrumentation at L5/S1, inpatient length of stay two days (22559, 22612, 22851, 20937, 22840).

**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)

**INFORMATION PROVIDED FOR REVIEW:**

<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>
724.3	22558		Prospective						Upheld

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient is male employee who suffered repetitive muscular strain injury to the lumbar spines. The examinee has a past history of a similar injury suffered in April XXXX. He has a past history of spine surgery occurring in April XXXX, leading ultimately to a fusion at the level of L4/L5 in 2003. He has had a number of straining-type lumbar spine

injuries. At the present time he has pain which radiates from the lumbar spine region into the right leg. He has had a number of evaluations. He has been treated with a physical therapy program, medications program, and selective nerve root injections. He has also had activity modification and is no longer employed as part. The examinee has received recommendation for anterior and posterior discectomy and fusion with instrumentation. This recommendation has been considered and preauthorization has been denied. It has been reconsidered and denied. Physical findings are limited. He has no deep tendon reflex abnormalities. Motor and sensory examination failed to reveal objective neurological compromise. Flexion and extension lateral x-rays failed to reveal evidence of instability.

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

The criteria published in the ODG Guidelines concerning preauthorization for lumbar spine fusion have not been met. This individual has suffered several episodes of lumbar spine strain. He has had persistent symptoms without objective physical findings of neurological compromise. It would appear that his current symptoms are on the basis of degenerative disc disease. The results of spinal fusion surgery for the diagnosis of degenerative disc disease under circumstances where degenerative disc disease is the etiology are not uniformly rewarding. It would appear that the previous denial of the request to preauthorize discectomy and fusion at the level of L5/S1 was 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).