

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 02/01/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Instrumentation removal and reinsertion at L4-L5
2. Transforaminal lumbar interbody fusion at L3-L4 and possible L2-L3
3. Decompression and instrumentation at L2 through L4 with a four-day hospital length of stay

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 chronic low back pain 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)

<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>
7213	22830		Prosp.	1	12/13/11 – 03/02/12				Upheld
7213	IPF01		Prosp.	4	12/13/11 –				Upheld

					03/02/12				
--	--	--	--	--	----------	--	--	--	--

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment.
3. Letters of denial 12/16/11 and 01/09/12, including criteria used in the denial.
4. PM&R physician’s office notes 02/10 – 06/14/11.
5. Treating doctor’s evaluations 08/18/11 & 09/09/11
6. Nurse’s notes 09/09/10 – 01/09/12

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The claimant is male who suffered a lumbar spine injury. He has had chronic low back pain and lower extremity pain for a number of years. The original date of injury was xx/xx/xx. The mechanism of injury is not described. He has undergone a number of surgical procedures for lumbar decompression and most recently a fusion at L4-L5. Recently, MRI studies have confirmed adjacent level disease at L3-L4 with potential stenosis at L2-L3. A recommendation has been made to remove the hardware at L4-L5, perform fusion from L2 through L5, and re-instrumentation with a four-day length of stay. This recommendation was considered and denied. It was reconsidered and denied.

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

It would appear that the claimant suffers chronic low back pain and extremity pain on the basis of a failed back syndrome. All potential pain generators have not been determined. It is documented that the claimant is a smoker. The ODG does not support fusion at more than two levels. It would appear that prior denial of the request to pre-authorize the removal of the internal fixation hardware, and further decompression and fusion at L2-L3 and L3-L4, was appropriate and should be upheld.

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

(Check any of the following that were used in the course of your review.)

- 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.

INDEPENDENT REVIEW INCORPORATED

- 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.)