



# PROFESSIONAL ASSOCIATES

**DATE OF REVIEW:** 05/24/07

**IRO CASE #:**

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

Lumbar decompression with fusion

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

Board Certified in Orthopedic Surgery

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An MRI of the lumbar spine interpreted by, M.D. dated 05/04/04  
Evaluations with, M.D. dated 04/01/05, 05/11/05, 05/20/05, 09/02/05, 09/23/05,  
11/09/05, 01/16/06, 02/03/06, 02/24/06, 03/10/06, 04/10/06, 05/22/06, 06/14/06,  
06/30/06, 07/17/06, 07/31/06, 11/03/06, 12/18/06, 01/24/07, 03/07/07, 03/21/07,  
04/04/07, and 04/16/07

A CT scan of the lumbar spine interpreted by Dr. dated 05/19/05  
Procedure notes from Dr. dated 08/18/05 and 10/27/05  
An operative note from Dr. dated 02/21/07  
A CT scan of the lumbar spine interpreted by, M.D. dated 02/21/07  
X-rays of the lumbar spine interpreted by, M.D. dated 02/21/07  
Letters of non-authorization from Center, dated 04/03/07 and 04/23/07  
An undated description of a spinal fusion

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

An MRI of the lumbar spine interpreted by Dr. on 05/04/04 revealed a disc bulge at L4-L5 and foraminal stenosis at L3-L4. On 04/01/05, Dr. requested a lumbar epidural steroid injection (ESI) and lumbar CT scan. A lumbar CT scan interpreted by Dr. on 05/19/05 revealed stenosis at L4-L5 and L5-S1. ESIs were performed by Dr. on 08/18/05 and 10/27/05. On 02/24/06 and 06/30/06, Dr. requested a lumbar discogram. A lumbar discogram interpreted by Dr. on 02/21/07 revealed concordant pain at L3-L4 and L4-L5. A post discogram CT scan interpreted by Dr. on 02/21/07 revealed possible disc herniations at L3-L4 and L4-L5. On 03/07/07, Dr. requested surgery and a lumbar MRI. On 04/03/07 and 04/23/07, HDI wrote letters of non-authorization for surgery. On 04/16/07, Dr. continued to request a lumbar MRI.

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

The patient has had a general and chronic lower back pain for over three years. The only positive finding suggestive of the need for fusion is a positive discogram. M.D. has provided a lot of literature references that demonstrate the lack of utility in using a discogram on individuals with secondary gain issues, most importantly workers' compensation. The patient has degenerative disc disease that was probably not aggravated by an injury on a more likely than not basis. The torn discs and discogenic disease were present long before his occupational injury. The change of success in this situation is very small. The indication for surgery does not exist. Therefore, in my opinion, the requested lumbar decompression with interbody fusion is neither reasonable, nor necessary as related to the original injury.

It should be noted that in the notes from Dr., he is also considering a selective endoscopy with annuloplasty and that the patient wishes to have the less invasive procedure on 03/07/07. It should be noted that this procedure is not clinically valid in cases of axial lower back pain and in no case should be approved. In short, I do not believe that either procedure recommended by the treating physician is reasonable, necessary, or effective in this individual's care.

**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 AND KNOWLEDGE BASE**
- 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)**