



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 09/25/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Interbody fusion and discectomy at L5-S1 with a one day length of stay

**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.

Interbody fusion and discectomy at L5-S1 with a one day length of stay - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by D.C. dated 02/05/07

Evaluations with M.D. dated 06/11/07 and 07/13/07

A lumbar discogram CT scan interpreted by M.D. dated 07/06/07

A Request for Preauthorization from Dr. dated 07/17/07

Psychological testing with, Ed.D. dated 07/23/07

A letter of non-certification, according to the Official Disability Guidelines (ODG), from Insurance dated 07/24/07

A letter of adverse determination from M.D., according to the ODG, dated 08/01/07

A letter of adverse determination from M.D., according to the ODG, dated 08/10/07

PATIENT CLINICAL HISTORY

The MRI of the lumbar spine interpreted by Dr. on 02/05/07 revealed a disc protrusion at L5-S1, facet synovitis at L1-L2, L2-L3, and L4-L5. On 06/11/07, Dr. recommended a lumbar discogram. The lumbar discogram CT scan interpreted by Dr. on 07/06/07 revealed low back severe low back pain at L2-L3 through L4-L5. On 07/13/07, Dr. recommended lumbar surgery and a psychological evaluation. On 07/23/07, Dr. felt the patient was a good candidate for surgery. Insurance wrote a letter of non-certification for the surgery on 07/24/07. Dr. wrote a letter of adverse determination for the surgery on 08/01/07. Dr. also wrote a letter of adverse determination for the surgery on 08/10/07.

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

The patient had an invalid discogram. That is, the patient had concordant pain at all levels. The decision to proceed with a one level surgery is not supported by the discogram. In addition, it has been shown in a prospective study that the type of complaints the patient has are not related to the occupational injury; that is, the lifting injury sustained is no more likely than any activity of daily living to create chronic pain, according to Eugene Carragee, M.D., and his coauthors in two excellent articles in 2005 and 2006, published in the *Journal of Spine* and the journal *Spine*. The complaints of pain are more likely than not psychological rather than physiological. In addition, the type of prosthesis that the operative surgeon wishes to use has never been validated. It has been placed in only several hundred people worldwide and there is no objective evidence that this type of procedure will provide long-term stable results. In addition, the ODG states that for this type of complaint, that is back pain due to degenerative disc disease, fusion is not recommended.

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)

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