

# Applied Resolutions LLC

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** 06/15/2008

**IRO CASE #:**

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

Anterior discectomy and interbody fusion

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

M.D., Board Certified Orthopedic Surgeon

## **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)

Upon independent review the reviewer finds that the requested anterior discectomy and interbody fusion is not medically necessary.

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

Adverse Determination Letter 4/24/08, 5/8/08  
ODG Guidelines and Treatment Guidelines  
Request for Pre-Authorization for Surgery 11/6/07  
Authorization After reconsideration Notice 12/13/07

MD Chart Notes 4/28/08, 11/5/07, 10/8/07, 1/15/08, 11/7/07, 3/8/07, 3/5/07, 2/13/07, 10/16/06, 9/22/06, 8/30/06, 8/7/06  
Health and Behavioral Assessment 11/4/07  
Discogram 11/2/07  
Caudal Epidural Steroid Block 9/24/07  
MRI's 9/17/07, 2/27/07, 1/6/07  
Designated Doctor Evaluation-Honaker, MD 6/25/07  
Report of Medical Evaluation 6/25/07  
MD 5/9/07  
DO Procedure 5/14/07, Pre-Injection Visit 5/14/07, Follow-Up Consultation 4/30/06  
MMI/IR 2/28/07  
DC 4/5/07, 4/23/08  
PhD 3/20/07  
Interdisciplinary Program Team Conference 3/20/07, 2/6/07, 2/20/07, 1/30/07, 1/9/07  
Laminectomy and Discectomy 8/29/06  
Comprehensive Re-Examination 11/2/06  
MR\_Lumbar Spine 9/2/05  
Electrodiagnostic studies 12/6/05  
Letter 5/30/08

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

This is a female with date of injury xx/xx/xx and previous laminectomy and discectomy at L4/L5 on 08/29/05. She apparently complains of low back pain with radiculopathy. She continues to have pain, mainly low back pain. She had failed epidural steroid injection. She has documented postsurgical change at L4/L5. She has had a discogram and post-discographic CT scan reproducing her pain at L3/L4, L4/L5, and L5/S1. There is no convincing evidence of instability at L4/L5, notwithstanding the previous laminectomy and discectomy.

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

Upon review of the provided medical records and ODG Guidelines, this reviewer finds that the requested anterior discectomy and interbody fusion is not medically necessary. The adverse determination for the underlying surgery has been upheld due to the fact that it does not conform to ODG Guidelines. The patient, while having previous surgery, has had provocative discography at four levels. ODG Guidelines and the literature do not support multilevel fusions beyond two. Two levels of fusion have been requested, but no explanation is given as to why the L3/L4 level, which is extremely concordant, should be left unfused. With this in mind, the adverse determination of the requested surgery has been upheld, due to the fact that the discography shows the level above at L3/L4 as abnormal and concordant in its pain reproduction and that the L2/L3 level is also abnormal though not probably a pain generator in this particular picture, it is hard to understand why only L4/L5 and L5/S1 are being recommended for surgery other than ODG Guidelines essentially restricting fusions to a two-level procedure.

**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)  
NORTH AMERICAN SPINE SOCIETY'S POSITION STATEMENT OF PROVOCATIVE DISCOGRAPHY