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## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

**DATE OF REVIEW:** 04/16/09

**IRO CASE #:**

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

Posterior Lumbar Discectomy and Fusion L4-L5

#### **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**

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#### **PATIENT CLINICAL HISTORY (SUMMARY):**

The claimant is an approximately female who sustained an injury in approximately xx-

xx-xx. She has been diagnosed with degenerative disc disease at L3/L4, L4/L5, and L5/S1. At L4/L5 there appears to be grade 1 degenerative spondylolisthesis with spinal stenosis. The patient complains of low back pain and radicular leg pain. Given her persistent back and lower extremity complaints, posterior lumbar interbody fusion surgery has been recommended at the L4/L5 level.

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

I have had the opportunity to review the information that has been provided and at this time, I do not feel there is enough medical documentation in the charts to support the requested surgery. First, there is no specific clarification from the primary surgeon on what the goal of surgery is. If the surgery is being predominantly recommended in an effort to alleviate low back pain, a low back pain generator has not been positively identified. Further, one of the dictations provided by the primary surgeon suggests that there is instability at the L4/L5 level. Other documentation suggests that this is not the

case. Patients with degenerative lumbar spondylolisthesis with resulting spinal stenosis will typically complain of radicular leg pain despite having a nonlocalizing neurological examination or normal nerve studies. Selective nerve root blocks are beneficial as a diagnostic intervention to get a sense of how well an individual would respond to surgery and though I understand that this patient has had transforaminal epidural steroid injections in the past, the degree of improvement is unclear by the medical documentation provided.

**OPINION DISCLAIMER:**

I certify that I have no relationship or affiliation to the beneficiary of this independent review or significant past or present relationship with the attending provider and/or treatment facility. I further certify that I have no familial or material professional or business relationship, or incentive to promote the use of a certain product or service associated with the review of this case. I further certify that I have no direct or indirect financial incentive for a particular determination or ownership interest of greater than 5% between any affected parties.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area, as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines, and peer consensus.

This review should not be used in violation of TDI-Division of Workers' Compensation rules or orders nor used to deny previously preauthorized care. The opinions rendered in this case are the opinions of the reviewer. The review has been conducted without a medical examination of the individual reviewed. The review is based on documents provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service or reconsideration may be requested. Such information may or may not change the opinions rendered in this report. This report is a clinical assessment of documentation and the opinions are based on the information available. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

**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)**