

SENT VIA EMAIL OR FAX ON  
Jun/01/2009

## Independent Resolutions Inc.

An Independent Review Organization  
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May/27/2009

### IRO CASE #:

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

Anterior lumbar interbody fusion L4/5 with 2-3 day inpatient stay.

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

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)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

MRI lumbar spine, 05/08/06, 08/09/06, 03/03/09

Office notes, PA-C, 01/17/08, 04/01/08, 08/27/08, 11/12/08, 12/30/08, 04/01/09

Office notes, Dr., 07/30/08, 03/11/09

Behavioral health assessment, 09/04/08

Discharge summary, 01/08/09

Denial of surgery, 04/08/09

Prospective review, Dr., 05/11/09

### PATIENT CLINICAL HISTORY SUMMARY

This is a female who was status post L4-5 discectomy in xxxx. The claimant has undergone three MRI's of the lumbar spine with the most recent MRI from 03/03/09 showing at the L4-5 level there were postoperative changes from right hemilaminectomy. No enhanced sequences were performed but there was no evidence of recurrent disc herniation. At the L2-3 and L3-4 levels, there were hypertrophic changes and mild canal stenosis. At the L5-S1 there was degenerative disc disease and a right paracentral disc protrusion. The fat signal was partially effaced in the right lateral recess. The claimant was evaluated on 04/01/09 for increased back pain to the right lower extremity. Examination revealed positive straight leg raise and decreased motor strength with dorsiflexion. It was noted "there were some signs of radiculopathy". Reportedly, x-rays showed L4-5 listhesis. An anterior lumbar interbody fusion was recommended.

### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

## **AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The request L4-5 anterior lumbar interbody fusion with two or three inpatient length of stay is not medically necessary based on review of this medical record.

This claimant had a previous L4-5 disc herniation with surgery and over time developed recurrent back pain. She had a 03/03/09 MRI of the lumbar spine whose report describes no malalignment and no recurrent disc herniation. She has been under the care of Dr. whose 04/01/09 office visit documents x-rays with an L5-S1 listhesis, although there is no documentation in the medical record of flexion/extension stress lateral x-rays or other corroborating evidence of x-ray abnormality.

ODG guidelines document the use of lumbar fusion in patients who have all pain generators identified and treated, physical medicine interventions are completed, x-rays demonstrate spinal instability, and a psychosocial screen has been performed. In this case, there is no evidence that a psychosocial screen was done. There is no documentation of structural instability at L4-5, and just because there is listhesis, does not mean it is an abnormal motion segment, and there is no documentation that the L4-5 disc has been proven to be painful. Therefore, the requested surgical intervention is not medically necessary.

Official Disability Guidelines 2009 Updates: Chapter low back: fusion

## **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)