



## REVIEWER'S REPORT

**DATE OF REVIEW:** 11/19/09

**IRO CASE #:**

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

Anterior lumbar interbody fusion, L5/S1

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients with spine problems

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. ZRC forms
2. TDI referral forms
3. Denial letters 10/09/09 and 10/26/09
4. URA records
5. Surgery scheduling slip 09/11/09
6. consultation, 09/11/09
7. X-ray report with flexion/extension laterals, 09/11/09
8. COPE psychological screening, 09/28/09
9. MRI scan of lumbar spines, 01/21/09
10. Lumbar myelogram with CT scan, 05/06/09
11. DNSA evaluation, 05/11/09, 03/30/09, and 02/16/09
12. evaluation, 05/18/09

13. Fax cover sheet, 10/06/09
14. Clinical notes, M.D., eight entries between 10/04/04 and 02/11/09
15. MRI scan of lumbar spines, 10/11/02
16. Progress note, 11/18/07
17. demographics, 09/11/09 with referral from Medical Center
18. Back pain questionnaire, 09/11/09
19. TWCC work status reports, 06/21/08 and 09/25/09
20. TWCC form #69, 09/25/09
21. M.D.
22. Designated Doctor Evaluation, 09/25/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This unfortunate male presents with complaints of low back pain and bilateral leg pain, more severe on the right than on the left. He has a past history of lumbar disc surgery in 2003. He had a recurrence of his pain occurring approximately 11/07/08. His low back pain is associated with no specific neurological findings documented suggestive of radiculopathy. He has special imaging studies suggestive of lumbar discectomy at L5/S1 with perineural scarring in the region of the S1 nerve root foramina on the right side. A request to perform anterior lumbar interbody fusion at L5/S1 has been considered and denied, reconsidered and denied. The patient has undergone epidural steroid injections without significant benefit. He has also been treated with medications.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

The flexion/extension lateral x-rays do not demonstrate instability at the level of L5/S1. The diagnosis appears to be degenerative disc disease without specific radiculopathy. In the absence of positive neurological findings suggestive of compressive neurologic disease, fusion does not appear to be appropriate.

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

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).
- \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)