



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 08/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Spine Anterior Interbody Fusion at L5-S1, Discectomy, as an Inpatient Procedure with a One Day Stay

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

Licensed 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.

Lumbar Spine Anterior Interbody Fusion at L5-S1, Discectomy, as an Inpatient Procedure With a One Day Stay - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MRI Lumbar Spine, M.D., 05/28/08
- Dermatomal Sensory Latency Study, M.D., 07/10/08
- MRI Lumbar Spine, Dr., 10/05/09
- Evaluation, M.D., 01/06/10
- Office Visit, Dr., 03/31/10, 04/28/10, 06/15/10
- Pre-Authorization Request, Dr., 05/24/10
- Notice of Denial of Pre-Authorization, 05/27/10
- Correspondence, Dr., 06/10/10
- Reconsideration Request, Dr., 06/15/10
- Notice of Reconsideration, 06/22/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had a history of a work related injury which resulted in severe pain in the area of her lower back. An MRI of the lumbar spine performed in 2008 revealed a large central posterior disc herniation of the extrusion type at L5-S1. She underwent a dermatomal sensory latency study of the lower extremities later on in 2008, which indicated a right L5 and right S1 radiculopathy. A follow up MRI of the lumbar spine performed in 2009 revealed again the large central posterior disc herniation of the extrusion type, at L5-S1, which measured 7-9.4 mm in AP diameter and 12 mm in length. Dr. felt the patient required a discography to make an assessment of possible previous types of pain which was later denied. Dr. then submitted a request for an anterior fusion at L5-S1 due to a lumbar disc herniation.

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

The medical records do not document medical findings that would support the requested surgical procedure under ODG criteria. There is no fracture or dislocation of the lumbar spine. There is no spondylolisthesis noted. There is no mechanical instability documented by MRI scan, CT scan, or conventional radiographs. This is not a third discectomy, and this is not a revision surgery. Therefore, the requested procedure does not meet ODG criteria.

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)