



REVIEWER'S REPORT

DATE OF REVIEW: 05/30/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Anterior and posterior discectomy and fusion, lumbar surgery L3/L4 and L4/L5

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

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

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a male. He suffered a twisting/straining injury to his lumbar spine region on xx/xx/xx. He has subsequently developed intermittent to almost constant low back pain with intermittent bilateral leg pain, numbness, and tingling. He has had numerous medical evaluations and special imaging studies. His special imaging studies have confirmed a diagnosis of degenerative disc disease and facet arthropathy involving L3/L4, L4/L5, and L5/S1. Physical findings reveal no reflex abnormalities. Straight leg raising test produces back pain and only intermittent leg pain. There are no objective findings of muscle weakness or sensory loss. His flexion and extension lateral x-rays failed to demonstrate instability. There are no images suggesting spondylolisthesis or spondylolysis. An anterior and posterior discectomy and fusion at levels L3/L4 and L4/L5 have been recommended, and preauthorization has been requested. The request has been considered and denied, reconsidered and denied.

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

The patient has no physical or radiographic findings suggestive of instability in the lumbar spine at motion segment. He has a suggestion of diagnosis of neurogenic claudication; however, there are no physical findings confirming such. He has been treated with epidural steroid injections without benefit and facet joint injections without long term benefit. The ODG 2010 Low Back Chapter specifically states that discectomy and fusion for degenerative disc disease is not a recommended procedure. It would appear that the prior denials to preauthorization the request for anterior and posterior discectomy and fusion were appropriate and should be upheld.

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, 2010, Low Back Chapter, Spinal Fusion passage
- 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.)