MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
2211 West 34th St. ● Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: X
Date of Amendment:X, X and X

IRO CASE #: **X**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN WHO REVIEWED THE DECISION

X.

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)

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INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Mechanism of injury:
The claimant is a X who was injured on X while X . The claimant was diagnosed with lumbar radiculopathy, bilateral leg pain, and s/p lumbar discectomy.

Diagnostic studies:
The claimant underwent a lumbar spine MRI with and without contrast on X. It showed X. X also had another lumbar spine MRI without contrast on X. It showed disc degeneration at X.

Surgeries:
The claimant underwent a X on X.

Conservative Treatment:
The claimant has been treated with X.

Medications:
The claimant is currently taking X.

Progress notes:
Orthopedic follow up by X dated X documented the claimant to have complaints of severe low back pain and severe left

leg pain. The claimant was diagnosed with other intervertebral disc displacement and X was recommended.

Denial Letter:
Prior UR dated X denied the request for X stating "The request is not medically necessary. The claimant continues to have low back pain, worsening left leg pain with radiation to foot, leg and buttocks on left, spasms, left side numbness and weakness. MRI shows X. Treatment to date includes X, X. The claimant has X. ODG requires instability or a third time decompression at the same level to qualify for fusion."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Recurrent intervertebral disc herniation is a relatively common occurrence after primary discectomy for lumbar intervertebral disc herniation. For recurrent herniations after repeat discectomies, a growing body of evidence suggests that X is effective in appropriately selected cases. Theoretically, X allows for comprehensive discectomy, less trauma to spinal nerves and paraspinal muscles and avoidance of the disadvantages of repeat posterior approaches. Indications for recurrent disc herniation discectomy surgeries are less well-defined. As revision surgery is more complicated, holding slightly worse patient outcomes and higher rates of complications including dural tears and nerve injury.

Currently, an additional micro-discectomy procedure is the most common surgical intervention pursued for recurrent disc herniations, however primary X has been practiced with potential indications such as lumbar instability or severe axial lower back pain. An anterior approach for X may offer an alternative option for patients who suffer from recurrent lumbar disc herniation. As for X used in the context of degenerative disc disease, the anterior approach theoretically allows for a comprehensive discectomy, less paraspinal muscle trauma and less nerve trauma from spinal nerve retraction. Specifically for recurrent disc herniations, a repeat posterior approach may result in higher risks of dural tears, more posterior bone removal to access the disc space, and an access corridor that may be impeded by residual tissue or epidural fibrosis. These complications can potentially be avoided via an anterior approach.

There is currently no gold standard treatment for operative management of recurrent lumbar disc herniations. Generally, the first-line treatment is an additional X. There is however growing evidence that fusion is efficacious in reducing dysfunction and pain in severe axial back pain, specifically when sacral tilt, and lumbar lordosis, is restored, although the approach remains a topic of ongoing debate. In a large-scale survey across 2,560 American spinal surgeons, there was a general trend for more experienced surgeons, defined as performing greater than 200 cases a year, to include a X as opposed to a standalone repeat

discectomy procedure in comparison to those performing <100 cases.

X is not routinely required in patients undergoing repeat laminectomy and discectomy for recurrent disc herniation. In the absence of objective evidence of spinal instability, recurrent disc herniation may be adequately treated by repeat lumbar laminectomy and discectomy alone.

The claimant, however, did have radiographic evidence of facet arthropathy which is a sign of early instability combined with asymmetric foraminal disc bulging and exaggerated lower lumbar with thoracolumbar rotatory dextroscoliosis. Having had a prior X left and X, the claimant now has left leg pain with radiation into the foot, leg, and buttocks with numbness and weakness. This constellation of clinical findings combined with advanced imaging findings do support a break with the ODG that usually requires a repeat microdiscectomy in most cases. This unusual case, specifically, does warrant the requested X.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG Criteria