

# IRO America Inc.

An Independent Review Organization

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## DATE OF REVIEW:

APRIL 2, 2007

## IRO CASE #:

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lateral interbody fusion L4-5, lateral retroperitoneal exposure and discectomy L4-5, lateral interbody fixation L4-5, posterior internal fixation L4-5, transverse process fusion L4-5, posterior decompression of L4-5, bone graft allograft in situ, bone marrow aspiration with a three day length of stay

## A 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)

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.

## INFORMATION PROVIDED TO THE IRO FOR REVIEW

Physical therapy notes 06/12/03

07/28/03

MRI lumbar spine 08/05/03

Office notes of Dr. 09/11/03

Office note of Dr. 11/25/03, 12/29/03

CT lumbar spine

Myelogram lumbar spine 12/29/03

Office notes of Dr. 12/24/04  
Office notes of Dr. 11/29/05  
FCE 12/01/05  
Letter of Dr. 08/29/06  
Review of medical records by Dr. 09/18/06  
Office notes of Dr. 11/15/06, 11/29/06, 01/24/07  
MRI lumbar spine 12/12/06  
Office note of Dr. 02/02/07  
Appeal Denial of Dr. 02/14/07  
Request for IRO 02/21/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a diabetic vending route driver who reported a vocational injury while lifting and moving totes full of food as noted in Dr. 07/28/03 peer review. The 07/28/03 functional capacity examination documented that the Patient was not yet ready to return to work. The 08/05/03 lumbar MRI of the spine showed a central disc protrusion at L3-4, and L4-5 disc spaces with obliteration of the epidural fat and impingement on the thecal sac. There was a mild degree of central spinal canal and lateral recess stenosis at L4-5 level. There was no evidence of spondylolysis or spondylolisthesis. There was minimal facet arthropathy noted in the lower lumbar spine.

Dr. saw the Patient on 09/11/03 and performed a medical record review. The Patient reported low back pain and numbness down the left lateral leg to his knee, mostly posterior. Examination revealed restricted lumbar range of motion, no significant difference between straight leg raise seated or supine and no focal neurological deficits. Dr.'s impression was acute lumbosacral strain, degenerative disc disease with central disc protrusion at L3-4 and L4-5. Dr. felt that there was no reproducible frank radiculopathy and with complaints of numbness would have expected more conclusive findings on the MRI. Dr. recommended no surgery and placed the Patient at maximum medical improvement with a 5 percent impairment rating.

The Patient saw Dr. on 11/25/03 for low back and bilateral lower extremity pain. The Patient noted no relief from physical therapy. Dr. felt that the MRI showed central disc bulges at L3-4 and L4-5, and possible lateral recess stenosis at L4-5. Exam findings revealed no clear cut weakness, symmetric reflexes and lateral recess stenosis at L4-5. Dr.'s impression was lateral recess stenosis with back and bilateral lower extremity pain. Dr. recommended a CT myelogram which was performed on 12/29/03 and showed a broad based disc bulge versus left paramedial disc herniation at L4-5. The 12/29/03 CT myelogram of the lumbar spine showed extradural defects at L3-4 and L4-5. Dr. reviewed the CT scan on 12/29/03 and felt that it showed bilateral restenosis at L3-4, central canal stenosis at L4-5 with herniated lumbar disc, central and to the left hand side with significant spinal stenosis. Dr. recommended lumbar decompression L3-4, lumbar laminectomy with discectomy and fusion L4-5.

Dr. performed an independent medical examination on 12/24/04. The Patient reported low back pain, pain to both legs and some numbness especially with the left leg. Exam findings were tenderness over lumbar spine, limited lumbar range of motion, and a positive supine straight leg raise on the left at 60 degrees. The seated straight leg raise was normal. The Patient was able to heel toe walk. Sensation and reflexes was intact. Reflexes were 4/4 bilaterally. Dr.'s impression was recurrent lumbar pain and treatment was related to the injury. Dr. recommended light duty, epidural steroid injection and follow up with Dr.. Dr. of neurology saw the Patient on 11/29/05 for a two and one half year history of progressive back pain. The Patient's exam revealed decreased sensation to the distal aspect of the left lateral thigh. Reflexes were absent at the ankles bilaterally. Right patella reflex was 3 plus and left was 2 plus. The Patient had good motor strength to his bilateral lower extremities and an active straight leg raise on the left to 10 degrees and 20 degrees on the right. Dr.' impression was lumbar disc disease, lumbar radiculopathy and low back pain. Dr. Cowens recommended functional capacity evaluation, electromyography, discogram, lumbar discectomy and off work.

The functional capacity examination on 12/01/05 recommended sedentary duty. The Patient performed at an inconsistent effort. Dr. saw the Patient on 08/09/06. Dr. reviewed the 08/05/03 lumbar MRI and the 12/09/03 Myelogram CT. Exam findings were pain with flexion, decreased range of motion with extension and rotation which produced pain bilaterally, and a negative seated straight leg raise. There was no weakness. Dr.'s impression was chronic unremitting lumbar radiculopathy, spinal stenosis at L3-4 and L4-5, and rule out discogenic pain in an insulin dependent diabetic. Dr. recommended a three level discogram.

The Patient was seen in follow up with Dr. on 11/15/06. Dr. noted that the discogram was denied. Dr. felt that the Patient had significant spondylosis at L3-4 and L4-5 with osteophytic lipping indicating instability at that level, central canal and lateral recess stenosis, facet arthrosis, calcification of facet capsules, left greater than right. Dr. felt that there was central stenosis at L4-5 from facet hypertrophy and arthrosis. Plain films revealed narrowing of L4-5 interspaces. The Patient reportedly received 10 percent relief from the epidural injections for two days. Dr. recommended total discectomy, interbody fusion at L3-4, L4-5, with posterior decompression, lateral mass fusion, segmental pedicle fixation through anterior approach and subsequent posterior approach. On 11/29/06, Dr. recommended an MRI of the lumbar spine to see if all pathology was limited to the L3-4 and L4-5 levels.

The 12/12/06 lumbar spine MRI showed multiple multifactorial degenerative changes within the lower thoracic and lumbosacral region. Central canal volume was most conspicuous at the L3-4, and L4-5 levels due to combine degenerative effects likely superimposed on congenitally short pedicles. There was no substantial focal disc protrusion and no high grade neural stenosis. Multiple level

narrowing of the neural foramina as a consequence of facet arthrosis and bulging disc material was noted.

Dr. felt that the 12/12/06 lumbar MRI showed significant pathology at L4-5 with disc space narrowing, central canal stenosis and a central left sided herniated disc pulposus. Dr. felt that the Patient had very subtle findings at L3-4 with facet hypertrophy at L5-S1. The Patient's symptoms were unremitting back pain with radiation into both legs down to the ankle on the left and to the proximal top of his foot but not into his toes and down midcalf on right. Dr.'s diagnosis was symptomatic herniated nucleus pulposus at L4-5 with spinal stenosis secondary to bilateral facet hypertrophy as well as bilateral facet effusions and encroachment on the exiting L4 nerve root and descending L5 nerve root. Dr. recommended a lateral interbody fusion at L4-5, posterior decompression and transverse process fusion at L4-5 with pedicle fixation. The 02/02/07 Utilization Review did not recommend the lateral interbody fusion L4-5, lateral retroperitoneal exposure and discectomy L4-5, lateral interbody fixation at L4-5, posterior internal fixation L4-5, transverse process fusion L4-5, posterior decompression L4-5, bone graft. There was no physician contact made. The reason for the denial was that a fusion is not recommended in the absence of spinal fracture, dislocation, spondylolisthesis or instability. A 02/14/07 appeal was upheld as the diagnostics did not show instability and performing a fusion in degenerative disc disease without evidence of spinal instability, listhesis or significant loss of expected disc height does not have predictable value and not recommended by the official disability guidelines.

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

The request for the lateral interbody fusion L4-5, lateral retroperitoneal exposure and discectomy L4-5, lateral interbody fixation L4-5, posterior internal fixation L4-5, transverse process fusion L4-5, posterior decompression of L4-5, bone graft allograft in situ, bone marrow aspiration, three day length of stay.

The requested L4-5 fusion does not appear to be medically necessary based on the information provided. This Patient has a history of lower back pain and has significant degenerative changes noted by objective x-ray and MRI studies. The most recent MRI performed on 12/12/06 showed no substantial disc protrusion and no high grade neuroforaminal stenosis. The Patient has bilateral lower extremity pain that does not correspond to any particular dermatomal pattern. The Patient has a history of lower extremity symptoms but does not appear to have specific lumbar radiculopathy. There is also concern regarding the documentation of an inconsistent effort on a Functional Capacity Evaluation. There is no evidence of instability in the records. Given the lack of documentation of instability, the lack of true radiculopathy or neural compressive pathology, I am unable to recommend the fusion as being medically necessary. The fusion procedure would be unpredictable for pain relief if being performed

simply for discogenic pain in the presence of degenerative changes without radicular pathology or instability.

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)