

P-IRO Inc.

An Independent Review Organization

1507 Frontier Dr.
Arlington, TX 76012

Phone: 817-235-1979

Fax: 866-328-3894

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient lumbar laminectomy/discectomy with a two day 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Lumbosacral MRI, 10/08/04 and 01/22/07

Notes, 03/30/05, 09/13/05, 12/13/05, 03/07/06, 08/15/06, 11/07/06, 01/23/07, 05/12/07

Consult for discogram, 02/23/07

Discogram, 05/02/07

Psychologic evaluation, 06/13/07

Peer review, 06/21/07 and 07/16/07

Request for medical dispute resolution, 07/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a history of neck and back pain. The claimant apparently underwent a cervical fusion and continued with low back and bilateral lower extremity

pain despite activity modification, therapy, injections and medications. Clinical findings on 05/12/07 noted bilateral sacroiliac joint and facet joint tenderness with decreased knee jerks bilaterally. Straight leg raise was positive on the left. The claimant had positive Laseque's and absent bilateral ankle jerks. Lumbar flexion and extension films on 11/07/06 revealed bone on bone spondylosis and stenosis, facet subluxation, and foraminal stenosis. There was retrolisthesis of 6 millimeters in extension at L5-S1.

MRI on 01/23/07 noted no abnormal findings at L5-S1 with minimal spondylosis at L3-4 and L4-5. A discogram on 05/02/07 reported no concordant pain elicited at any lumbar level. The impression noted the claimant's pain was most likely generated from the spondylosis. The impression was lumbar spine instability at L5-S1 with spondylosis, retrolisthesis, and failed conservative treatment. Lumbar laminectomy/discectomy with stabilization at L5-S1 were proposed.

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

This female reportedly injured herself. Subsequently she appears to have complained of a combination of back and bilateral leg pain. She has received extensive treatment by history. Multiple MRI scans were referenced in the records which document mild spondylitic change at multiple levels but no evidence of discrete disc herniation or distinct nerve compression. Furthermore, there is no evidence of significant foraminal stenosis. More recently, she underwent discography which was described as being negative at all levels.

Finally, from an imaging study standpoint, she has plain flexion/extension radiographs which reportedly showed 6 millimeters of retrolisthesis on extension. Clinical records do not however, document progressive neurologic deficit or obvious clinical change in recent months.

The request was to evaluate this particular individual in the context of proposed lumbar laminectomy and discectomy with a two day overnight stay in the hospital. At this point in time the Reviewer cannot recommend the proposed surgery as either being reasonable or medically necessary. The imaging studies themselves do not document significant signs of nerve compression i.e. no disc herniation or significant stenosis. Although there may be some degree of dynamic instability that could account for some radicular leg complaints, the Reviewer's medical assessment that the proposed surgery i.e. decompression and discectomy, would not satisfactorily address that particular underlying pathology.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates (Low back)

ODG Indications for SurgeryTM -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy L5 nerve root compression, requiring ONE of the following:

1. Severe unilateral foot/toe/dorsiflexor weakness/mild

atrophy

- 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- S1 nerve root compression, requiring ONE of the following:
- 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

II. Imaging Studies,

III. Conservative Treatments

Fusion

Not recommended for patients who have less than six months of failed conservative care unless there is severe structural instability and or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise,

Patient Selection Criteria for Lumbar Spinal Fusion:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include:

- (1) Neural Arch Defect –
- (2) Segmental Instability –
- (3) Primary Mechanical Back Pain/Functional Spinal Unit Failure,
- (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated.
- (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion include all of the following:

- (1) All pain generators are identified and treated; &
- (2) All physical medicine and manual therapy interventions are completed; &
- (3) X-ray demonstrating spinal instability and/or MRI, Mylogram or CT discography demonstrating disc pathology; &
- (4) Spine pathology limited to two levels; &
- (5) Psychosocial screen with confounding issues addressed.
- (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

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)