

# True Resolutions Inc.

An Independent Review Organization

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## DATE OF REVIEW:

8/24/07

## IRO CASE #:

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Spinal Surgery (LOS)

## 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

7-25-6 PT note 8-8-6 MD, 8-15-6 MD 8-21-6

MD 8-29-06 9-1-6 11-6-6

HealthCare, DC 11-8-6 Utilization Review 11-17-6

Left and right Knee XR 11-17-6 MRI knee 11-29-6 MRI lumbar 12-1-6

MD 12-20-06 FCE 1-8-7, MD 1-23-7 Op Note. by Dr. 2-1-7 3-7-7 MD 3-26-07

letter of Utilization Review Determination. Peer reviewer 4-26-07

letter of Adverse Determination 7-31-7 Letter

## PATIENT CLINICAL HISTORY [SUMMARY]:

**7-25-6 PT note.** Otj x-xx-x slipped and fell on wet floor. c/o back, neck both knees and entire body. c/o back and bil leg 10/10 K's and pTpC bil; neck and arm pain. PE ag/nl posture/sens/dtrs/knee rom/knee rom pain with f/e/ detailed knee exam done/ tender l JL>medial JL/ LE mmt grossly 4/5/ dtrs/ sens/ rts + bil not defined/ Faber + bil/ 3/5 Waddell/ Imp K and LB strain. Plan PT.

**8-8-6, MD.,** PE detailed. Plan: Voltaren, Lorcet. RTW LD.

**8-15-6 MD** c/o k and back. PE detailed neuro neg/ detailed K neg/ Neg Waddell's. IMP K and lb strain. RTC prn.

**8-21-6 MD** ov. c/o lb and bil leg 10/10. Inc bending, walk, lift. pT/pC bil. PE full rom/ no dysm/ flip/ kjs and ajs/ mmt detailed/ hip rom/ neg slr/ sens/ knee detailed/ XR back and K nl. IMP lumbar strain with monor sprain of bil Ks. May be symptom magnification present. Clinoril, rtw ld tomorrow.

**8-29-06** Went ER due to pain. K aspirated and terrible pain.

**9-1-6** “hysterical” with pain in both K’s “highly inappropriate”. No fluid aspirated at ER. PE no effusion/ nl knee exam/ C/o radiating bil leg pain “which is totally unverifiable”. IMP “this lady is hysterical with conversion reaction” TX Ultram. RTWLD she is not happy about that. No objective evidence of new injury.

**11-6-6 HealthCare DC.** neck, lb, bil Ks 8/10. Rec imaging, active ex program, passive modalities.

**11-8-6 Utilization Review.** Rec PT 9 visits.

**11-17-6 Left and right Knee XR:** negative

**11-17-6 MRI knee.** Small effusion, tear lat meniscus, bil OA. Baker’s cyst. Bone bruise is suggested.

**11-29-6 MRI lumbar.** Focal ml prot 45 no nr; 51 central disc bulge with mild foram. No nr. 12, 23, 34 normal.

**12-1-6 MD.** Ortho. C/o lbp radiating to left hip and bil K. PT, DC. Lorcet, Soma. Can only sit 10 minutes > lb and Knees. Lying down no help. Lbp 7-8/10. PE slr/ mmt/ sens/ IMP meniscal tear bil. HNP 45 and 51 with radicular pain to left B. Plan ESI’s.

**12-20-06 FCE** unable to rtw as nurse assistant. OK for sedentary. 76% Oswestry.

**1-8-7 MD,** occ med, peer review. Doesn’t think esi’s are efficacious in general and not for this case as there are no c/o of radic.

**1-23-7 Op Note. A/A by Dr.** For right meniscal tear and chondromalacia.

**2-1-7 c/o signif lbp.** MRI reported central post hnp 45 and 51 with foram narrowing. [no c/o leg, no neuro, no correlation with imaging] Plan: discography and plasma disc decompression which would give us diagnostic information about where her pain is coming from as well as therapeutic result. This would avoid any future larger operations such as disc replacement or fusion surgery. Rec PT in meantime.

**3-7-7 MD.** Ortho. C/o significant/severe back and bil leg pain 10/10. PE neurologically intact. Plan: Waiting for final decision for discography and plasma disc decompression for hnd’s at 45 and 51.

**3-26-07 letter of Utilization Review Determination. Peer reviewer MD board ortho.** ACOEM, Spine Rothman, AAOS OKU 5<sup>th</sup> ed, ODG. Pt has multilevel DDD w/o neuro compressive lesion, no instab. No documented nonsurg tx. Plasma disc decompression no peer reviewed scientific long term success rates. No indication that even if indicated, this procedure is more efficacious than standard LL&D.

**4-26-07 letter of Adverse Determination.** Noncert based on insufficient evidence of precut plasma disc decompression and other forms of nucleoplasty. ODG 2007: precut laser discectomy not recommended based on extremely low level of evidence...

**7-31-7 Letter** Psychological overlay.

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

A lumbar discectomy, regardless of technique, is performed for a diagnosis of herniated disc for patients who complain of the following: sciatica symptoms (radicular pain, dermatomal numbness, and weakness) that are corroborated by both physical exam findings and corresponding imaging findings of a herniated disc that is causing specific nerve root compression. This patient has no complaints of sciatica, nor did she have appropriate physical exam findings of a lumbar radiculopathy as documented by several healthcare providers. Her complaint of hip pain was probably referred pain from the lower back rather than radicular pain because of the absence of root tension signs that reproduced buttock pain. Additionally, there is no literature to support a lumbar discectomy for treatment of axial back pain. References: any textbook of low back pain, e.g., Low Back Pain, Borenstein and Wiesel.

The most recent published literature review of lumbar discectomy interventions for lumbar herniations (Gibson, JN; Waddell, Gordon; Surgical Interventions for Lumbar Disc Prolapse: Updated Cochrane Review; Spine: Volume 43, 15 July 2007; pp 1735-1747) concluded that techniques other than microdiscectomy, including coblation therapy (plasma disc decompression), should be regarded as research techniques because of the lack of peer reviewed literature to support it. There are no randomized control trials studying the efficacy of coblation therapy of lumbar disc herniations.

**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 LISTED ABOVE
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)