

# P&S Network, Inc.

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**DATE OF REVIEW:** December 26, 2007

**IRO CASE #:**

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This case was reviewed by an orthopedist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Anterior lumbar interbody fusion and decompression

## **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o November 12, 2007 utilization review report from
- o November 26, 2007 utilization review report from
- o xx/xx xx employers first report of injury or illness, unsigned
- o xx/xx/xx associate statement workers' compensation signed by the patient
- o July 29, 2005 request for leave of absence from the patient
- o June 21, 2005 through July 8, 2005 chart notes with illegible signature
- o July 18, 2005 x-ray report by, M.D.
- o July 19, 2005 MRI report by, M.D.
- o July 29, 2005 through August 6, 2005 chart notes with illegible signature
- o September 2, 2005 through November 9, 2005 work status reports from, D.O.
- o October 17, 2005 consultation report from, M.D.
- o November 9, 2005 consultation report by, M.D.
- o November 10, 2005 pain management consult report by, M.D.
- o December 12, 2005 operative report for epidural cortisone injection by, M.D.
- o December 21, 2005 report of medical evaluation by, D.C.
- o December 21, 2005 report of impairment rating evaluation by, D.C.
- o December 21, 2005 functional capacity evaluation report from Therapy Associates
- o January 10, 2006 follow-up chart note from, M.D.
- o January 20, 2006 patient education notes by, R.N.
- o January 20, 2006 internal medicine consultation report by, M.D.
- o January 27, 2005 behavioral medicine evaluation by, Ph.D.
- o January 30, 2006 operative report by, M.D.
- o February 27, 2006 through June 6, 2006 work status reports by, M.D.
- o June 6, 2006 notes from, Ph.D.
- o July 21, 2006 lumbar MRI report by, M.D.
- o July 21, 2006 lumbar x-ray report by, M.D.
- o July 27, 2006 history and physical report by, M.D.

- o August 1, 2006 follow-up note by, M.D.
- o August 9, 2006 lumbar discogram report by, M.D.
- o August 9, 2006 CT lumbar spine with contrast limited report by, M.D.
- o August 15, 2006 follow-up note from, M.D.
- o September 5, 2006 report of medical evaluation by, M.D.
- o September 25, 2006 follow-up note by, M.D.
- o October 24, 2006 report of medical evaluation by, D.C.
- o March 15, 2007 through August 14, 2007 follow-up notes by, M.D.
- o April 10, 2007 MRI report by, M.D.
- o July 30, 2007 reported medical evaluation by, M.D.
- o August 14, 2007 follow-up note from, M.D.
- o August 20, 2007 consultation report by, P.A.-C.
- o September 5, 2007 CT lumbar with contrast report by M.D.
- o September 5, 2007 lumbar myelogram report by, M.D.
- o September 18, 2007 follow-up note from, M.D.
- o September 27, 2007 psychological report by, Ph.D.
- o October 4, 2007 telephone notes slight, Ph.D.
- o October 9, 2007 consultation report by, D.O.
- o October 22, 2007 letter by, Ph.D.
- o November 7, 2007 follow-up note by, D.O.
- o November 16, 2007 office note by, Ph.D.
- o November 26, 2007 follow-up note by, M.D.
- o December 3, 2007 follow-up note by, D.O.
- o October 18, 2005 through April 14, 2006 physical therapy notes from General Hospital

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving the lumbar spine. A November 12, 2007 utilization review report rendered a non-certification for anterior lumbar fusion and decompression. The report states that there is no evidence that the patient had returned to work after prior spinal surgery. A psychological evaluation revealed significant issues for delayed recovery and failed back. There was no evidence of instability and the request was stated to not have been consistent with published guidelines for this xx year old.

A November 26, 2007 utilization review report also rendered a non-certification for the request. The reasons provided included that there was really no evidence of a progressive neurological deficiency. The peer-review physician stated that there was no evidence of instability or a defined pain generator. The physician reviewer spoke with the requesting physician who reportedly indicated that he complains the pain is coming from L4-5. The report states that he underwent bilateral subtotal decompressive laminectomies at L4-5 on January 30, 2006. According to the report, a behavioral medicine evaluation was carried out on January 27, 2005 demonstrating abnormalities. Axis I indicated psychological factors affecting physical condition with no Axis II diagnosis. It was indicated that the patient's MMPI was completed but the results were pending. The reviewer summarizes the case by saying that the patient is a young adult male who sustained a work-related injury with back pain and leg pain. Review of numerous clinical documents demonstrates variances in the patient's clinical findings and the majority of the patient-provider contacts contained no physical examination of the patient. The report notes that per the Official Disability Guidelines Treatment Index and the ACOEM guidelines, there does not appear to be any medical basis to recommend an ALIF at this time given the lack of any objective clinical documentation indicating the necessity of stabilization with or without internal fixation.

The patient underwent physical therapy between October 18, 2005 and April 14, 2006. On April 14, 2006 the patient reportedly stated that he did not wish to be treated and wanted to be discharged as he felt 80% relief from pain. He stated that the radiating pain and numbness to his right leg had eased completely. He reported that he was able to ambulate on his own around his neighborhood in the evening. He was performing home exercises and did not feel the need for further supervised physical therapy.

An April 10, 2007 lumbar spine MRI report includes an impression of status post bilateral laminectomies at L4-5; enhancing granulation tissue within the anterior and right lateral aspect of the spinal canal at L4-5; a small focus of soft tissue intensity within the left side of the spinal canal anteriorly, a small focal disc fragment within the left anterior aspect of the spinal canal cannot be excluded; clinical correlation for a left L5 radiculopathy suggested; and a suggestion for possible myelography.

A July 20, 2006 lumbar spine x-ray report includes an impression of no evidence of acute compression fractures or subluxations. A July 21, 2006 lumbar spine MRI report includes an impression of postoperative changes seen at L4-5. On the postcontrast study, there is a triangular shaped low signal area seen at the discectomy site of the right side surrounded by enhancing fibrosis suggesting small residual fragment. There is mild mass effect seen on the thecal sac on the right side with impingement on the nerve root. Persistent bilateral foraminal narrowing at L4-5 was noted. There was resection of the ligamentum flavum on the right side with partial laminectomy. No abnormal fluid collections were seen in the spinal canal or at the surgical site. Enhancement within the disc at L4-5 suggested diskitis.

A lumbar discogram was performed on August 9, 2006. At L4-5 there was decreased resistance, degenerative and epidural leak,

discordant pain/pressure, and a pain score of 6/10. At the L5-S1 level there was firm resistance, normal architecture, discordant pain/pressure, and a pain score of 7/10. At L3-4 the resistance was firm, architecture was normal, and there was no pain or pressure. A post CT was performed and demonstrated diffuse disc fissuring along the posterior, right lateral and anterior margins of the L4-5 disc. Contrast was noted to be extending into the right ventral epidural space and an underlying disc protrusion at that level could not be excluded.

The patient underwent a designated doctor evaluation on September 5, 2006. Relevant physical examination findings included weakness in the right great toe extensor on the left rated at 2/5, no weakness in the dorsiflexors or plantarflexors, Achilles reflex on the right at 1+ in the left greater than a 1+, ability to walk on toes and heels, sensory examination to pinprick and light touch intact, and no noted atrophy. The physician stated that the patient had not reached maximum medical improvement and without further surgery would reach the status in December 2006. If the patient had surgery with fusion it would be extended for an additional 12 months and MMI status would be anticipated in October 2007.

A designated doctor evaluation was performed on July 30, 2007. The report states that the patient obtained MMI status as of July 3, 2007. The physician opined that the patient is able to return to work at a moderate duty capacity. The future treatment section of the report states that the examinee denies any future contemplated or scheduled cervical or non-surgical therapy.

A September 5, 2007 lumbar myelogram report includes findings of some narrowing at the L4-5 level.

The patient was referred for presurgical psychological screening on September 27, 2007. The conclusion was that the patient had two significant issues that needed to be addressed before he is an acceptable candidate for spine surgery. The issues included panic attacks and limited motivation for spinal fusion. On October 4, 2007, a letter from the psychologist states that the major issues which were obstacles to surgical clearance when the patient was last talked to including low motivation for the fusion and panic attacks are now resolved sufficiently. The patient was cleared from a psychological standpoint for surgery.

An August 20, 2007 report states that the patient came in for a second opinion. The patient reported that following his surgery in January 2006 his right leg pain completely resolved but the back pain worsened. After about a year after surgery he began to complain of left leg pain. The pain has reportedly progressed and it presents along the lateral aspect of the left leg and into the left anterior thigh. Examination findings included normal gait, normal toe/heel walk, lumbar flexion to 90 degrees, extension slightly uncomfortable, pain reproduced on the left with facet loading but not with twisting or lateral bending, seated straight leg raise negative bilaterally, 5/5 motor strength throughout, symmetric patellar and Achilles reflexes, and no hyperreflexia.

September 5, 2007 lumbar spine CT scan report states that there is a large 6 mm central disc protrusion indenting the ventral aspect of the thecal sac at L4-5. The exiting nerve root sleeves were filled with contrast and did not demonstrate significant displacement. On the right side, mild right lateral recess narrowing without definite right foraminal narrowing or nerve root impingement was noted. Moderate left lateral recess narrowing was visualized. There was moderate degenerative facet hypertrophy for the age bilaterally at this level. There appeared to be a probable remote fracture or developmental anomaly of the left L4 inferior articular facet. It did not appear to represent an acute fracture but did demonstrate some adjacent degenerative change. Correlation with MRI was suggested to determine whether there is marrow edema associated with this finding which could account for the patient's symptoms. Some contrast dorsal to the thecal sac at the L4-5 level was seen which may be related to the injection of contrast. The previous laminectomy was noted. The central spinal canal at L4-5 measured 8.6 mm and by contrast, the central spinal canal at L3-4 measured 10.3 mm.

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

The patient has failed the January 2006 laminectomy as his back pain has worsened since that time. He has developed right leg pain and a recurrent protrusion causing indentation upon the thecal sac at the L4-5 level. His physical examination has been somewhat inconsistent, however, this can be expected in a case of a central protrusion. He meets indication number (4) per the Official Disability Guidelines as he had a failed previous operation. Regarding pre-operative surgical indications the patient meets number (3). He does not demonstrate spinal instability upon x-ray but he meets the criteria as imaging has demonstrated disc pathology. All physical medicine and manual therapy interventions have been completed. Spine pathology is limited to two levels. The patient has been cleared with a psychosocial screen for confounding issues. Therefore, my recommendation is to overturn the decision to non-certify the request for anterior lumbar interbody fusion and decompression.

The IRO's decision is consistent with the following guidelines:

#### **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 KNOWLEDGBASE

\_\_\_\_ 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
- X 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

### Official Disability Guidelines (2007):

#### 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 - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical disectomy. [For excessive motion criteria, see AMA Guides, 5th Edition, page 384 (relative angular motion greater than 20 degrees). (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. [For spinal instability criteria, see AMA Guides, 5th Edition, page 379 (lumbar inter-segmental movement of more than 4.5 mm). (Andersson, 2000)] (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should 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-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI 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. (Colorado, 2001) (BlueCross BlueShield, 2002)

