

## **IRO REVIEWER REPORT**

**DATE OF REVIEW:** 02/26/07

**IRO CASE NO.:**

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

Request for lumbar 360 degree fusion at L4-S1 with a two day stay at.

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

currently listed on TDI DWC ADL  
Board Certified Neurosurgeon

**REVIEW OUTCOME:**

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

Upheld.

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

1. Cover sheet and faxed cover sheet.
2. MRI report dated 04/15/00.
3. MRI report dated 04/30/00.
4. Clinic note dated 02/08/06.
5. MRI report dated 02/27/06.
6. Follow-up note dated 03/08/06.
7. Initial history and physical dated 05/08/06 by Dr.
8. Lumbar discogram procedure note dated 06/15/06.
9. Post discogram CT report.
10. Follow-up note by MP, dated 06/26/06.
11. Follow-up note by Dr. dated 10/19/06.
12. Internal behavioral medicine evaluation dated 12/11/06.
13. utilization review determination.

14. utilization review determination dated 01/04/07.

15. Request for hearing dated 02/15/07.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a male whose date of injury is listed as. The clinic notes indicate that the employee sustained an injury to his low back on when he was climbing a ladder which began to collapse. The employee was noted to have been able to hold onto a rafter and twisted his back in doing so. The employee eventually fell down approximately four feet, landing on his feet. The employee did not notice immediate back pain; however, the next day he began to experience some back discomfort. The employee reported that his symptoms had worsened over the first year and gradually worsened since then. The employee was noted to have dull soreness of varying degree from stabbing sensation in the low back and bilateral lower extremity symptoms of numbness and tingling.

The employee has noted that the numbness and tingling in the lower extremities resolved approximately one year ago. This was reported from the clinic note dated 02/08/06. The clinic note also indicated that the employee denied any bowel or bladder symptoms; however, his low back pain worsened with almost any activity. The employee has undergone previous non-operative treatments including physical therapy, chiropractic treatment, and injections. The chiropractic treatment and injections have noted to provide minimal relief. The employee is currently using a neuromuscular stimulator at home and has undergone EMG/NCV studies, as well as multiple MRIs.

The most recent physical examination provided by Dr. is dated 10/19/06, which noted the employee had 5/5 motor strength bilaterally in the lower extremities as well as intact sensation. Straight leg raise testing was normal, and deep tendon reflexes were symmetric. No long tract signs were present. In review of the imaging studies, there was an MRI performed on 04/15/00 which noted a small broad-based central and left paracentral disc protrusion at L3-L4, as well as a tiny right minimal posterior endplate spur at L5-S1 with a tiny paracentral disc protrusion present. L4-L5 noted a moderate degree of desiccation of the disc, as well as small broad-based central and left paracentral protrusion with subligamentous herniation. The employee underwent a repeat MRI of the lumbar spine on 04/30/03 which noted no disc displacement at L3-L4 and patent canal and neural foramina. L4-L5 noted a small 2 mm posterior central disc protrusion which mildly effaced the thecal sac. Again, the canal and foramina were patent at this level. At L5-S1, there was a 4 mm posterior central disc protrusion which mildly impinged upon the thecal sac, and both the S1 nerve root sheaths showed impingement in the lateral recesses. Another repeated MRI of the lumbar spine was performed on 02/27/06, which noted mild generalized annular disc bulging at L3-L4 with no significant stenosis. L4-L5 showed a central disc protrusion measuring 3-4 mm in AP diameter. There was

indentation of the thecal sac at the midline; however, there was extension more to the left than right of midline. No nerve root compression was noted. L5-S1 was noted to show central disc protrusion measuring 3-4 mm in AP diameter and no significant mass effect on the S1 nerve root was noted, as well as no significant stenosis. The EMG report was not submitted for review, and the clinical information provided does not indicate the results of the electrodiagnostic testing.

The employee underwent discogram on 06/15/06. The report of the discogram noted that the employee had no pain at L3-L4, discordant pain at L4-L5, and concordant severe low back pain at L5-S1. Post discogram CT noted that the employee had a large diffuse disc bulge at L2-L3 with multifactorial central stenosis and contribution of foraminal stenosis due to disc bulging. Mild facet arthropathy was noted to be present at this level. L3-L4 noted a prominent central contrast collection consistent with a normal discogram. Diffuse disc bulge was present at that level as well. Mild narrowing of the inferior aspect of the neural foramina was present. Mild facet hypertrophy was noted at L3. At L4-L5, there was a contrast collection centrally within the disc and prominent annular rent with central radial fissure. Diffuse disc bulge and superimposed broad-based central protrusion was present which abutted the ventral aspect of the thecal sac. Bilateral recess narrowing was present, particularly rightward. There was mild central stenosis and facet arthropathy. L5-S1 noted diffuse contrast dispersion throughout much of the disc with severe internal disruptive changes noted. There was a central annular rent and radial fissure. There was centra/right paracentral protrusion present, which effaced the ventral thecal sac and abutted or nearly abutted the S1 nerve roots and ventral thecal sac. Borderline central canal narrowing was noted.

Prior to the discogram, Dr. performed a physical examination which contradicted the examination by Dr.. The employee was noted to have decreased lumbar range of motion with 20 degrees extension, 60 degrees flexion, and 10 degrees right and left lateral flexion. was negative bilaterally. Sensation was noted to be normal on the left and decreased on the right. Straight leg raise was normal on the left and increased on the right; however, there was no degree and does not indicate if it is back or leg pain. Deep tendon reflexes were also in contradiction. Patellar reflexes were 1+/4 bilaterally, and Achilles was 2+/4 bilaterally. Motor strength was noted to be decreased on the right in the dorsiflexors of the ankle and plantar flexors of the ankle. The employee was noted to have increased pain with hyperextension.

The employee has been submitted for a behavioral medicine evaluation on 12/11/06. This was performed by COPE, which is a chronic pain management program. This was also an internal office for the. The behavioral medicine evaluation noted the employee was not currently taking any antidepressants; however, the note indicated that he was sometimes so depressed that he had to just stay home. In addition, the employee noted financial difficulties and stated that his workers' compensation disability payments had ended, and he was now on Social Security Disability income. The behavioral medicine "Expectations for Treatment

Outcome” section noted that “he is somewhat anxious about the surgery, but feels he has no choice if he wants to be more active. He really does not expect to return to work.” The conclusion noted that the employee, based on the Presurgical Psychological Screening interview noted that the employee was “clear for surgery, with a fair prognosis for pain reduction and functional improvement.” The note also indicated that the employee has a high degree of pain sensitivity and somatic anxiety. There was also mention that the employee should be approached utilizing a behavioral emphasis and minimal attention paid to his pain complaints. The note stated that the employee needed a “great deal of information and structure in order to achieve maximal gains from the surgery.”

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

The request for lumbar 360 degree fusion at L4-S1 with a two day stay at Center for diagnosis and surgery is not medically necessary. The employee did not undergo an independent psychological evaluation for his preoperative evaluation; however, the internal report actually does support the employee having surgery despite the information noting that the employee has severe anxiety regarding surgery, no ambition to return to work, and focus on disability. It appears this employee is not an appropriate candidate from a psychological standpoint for surgical intervention.

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

1. *American College of Occupation and Environmental Medicine*, Chapter 12, Page 307. Accessed: 02/23/07.
2. *Official Disability Guidelines*.