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DATE OF REVIEW: 07/06/2007

IRO CASE #:

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

This case was reviewed by a Orthopedic Surgeon. 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: L3-4 laminectomy and foraminotomies with transforaminal lumbar interbody fusion and PSF L3-4

REVIEW OUTCOME:

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

UPHELD (agreed)

REVIEW OF RECORDS:

- o Submitted medical records were reviewed in their entirety.
- o April 23, 2007 utilization review by D.O.
- o May 23, 2007 utilization review by M.D.
- o June 6, 2007 letter to injured employee from
- o June 6, 2007 request for a review by an independent review organization
- o June 27, 2007 submission of request for IRO from Attorney at Law
- o June 27, 2007 confirmation of receipt of request for a review by an IRO from Texas Department of Insurance
- o June 17, 2005 post-myelogram CT report of the lumbar spine signed by M.D.
- o February 19, 2003 post discography CT of the lumbar spine report by M.D.
- o April 29, 2004 flexion/extension lateral views of the lumbar spine report by M.D.
- o December 17, 2003 lumbar MRI report from MRI Group
- o October 22, 2002 lumbar MRI report by M.D.
- o February 19, 2003 radiology report from Medical Associates
- o June 23, 2005 EMG/NCV report by M.D.
- o November 12, 2002 electrodiagnostic report from M.D.
- o December 19, 2003 report of medical evaluation
- o December 19, 2003 designated doctor evaluation report by M.D.
- o February 5, 2004 procedure note for a caudal epidural steroid injection by M.D.
- o March 10, 2004 procedure note for epidural lysis of adhesions by M.D.
- o April 14, 2004 procedure note for epidural lysis of adhesions by M.D.
- o August 2, 2004 through January 2, 2007 chart notes and reports from M.D.

CLINICAL HISTORY SUMMARY: The injured employee is a male who sustained an industrial injury involving the lower back. An April 23, 2007 utilization review report states that there are old imaging studies that showed disc changes at L3-4 and fusion at L4-5 and L5-S1 levels. However, the physician reviewer stated that the records fail to indicate that the patient has undergone recent conservative care and a non-certification was rendered. A second utilization review, dated May 23, 2007, states that it is virtually certain that the requested surgery will not eliminate the patient's pain or return him to work.

On December 19, 2003, the patient saw a designated doctor. The report includes an impression of recurrent disc herniation seen on the recent MRI. The physician opined that the patient had not reached maximum medical improvement, continued to have radiculopathy, and required a redo procedure for his significant protrusion.

Flexion-extension x-rays were performed on April 29, 2004 of the lumbar spine with no evidence of instability during flexion and extension. The L5 vertebra appeared transitional.

The patient underwent fusion at L4-5 and L5-S1 on October 4, 2004. Notes from October 25, 2004 indicate that the patient felt great following the surgery and was making progress every day. He underwent postoperative physical therapy and occupational therapy. Chart notes from May 24, 2005 states that the patient reported leg numbness and bilateral groin pain. An EMG was ordered to rule out lower extremity radiculopathy. The injured employee underwent a lumbar spine post-myelogram CT on June 17, 2005 with an impression of normal findings at

L1-2 and L2-3. A broad 2.0 mm disc protrusion/herniation was noted at L3-4 with mild central canal stenosis and mild bilateral neural foraminal narrowing. The L3 nerve roots were said to be possibly impinged upon centrally near their origins. At L4-5 and L5-S1, status post posterior spinal fusion changes were noted with no recurrent or residual disc herniation, canal stenosis, or neural foraminal encroachment. An electrodiagnostic study was performed on June 23, 2005 with an impression of evidence of an old S1 radiculopathy with no evidence of any acute radiculopathy.

Notes from July 25, 2005 indicate that the injured worker had the CT myelogram which revealed adjacent-level disease with spinal stenosis at L3-4. The injured employee had a solid appearing fusion from L4 through S1. Epidural injections for the L3-4 level were recommended. Chart notes from October 31, 2005 state that the injured employee has had his injections. He reported some relief from the first injection. The patient indicated that he feels he should have more epidurals since the first one helped and the physician agreed that it was clinically appropriate.

Notes from March 27, 2006 state that the injured employee had his injections at the L3-4 level and continues with back and leg pain. The physician recommended possible L3-4 decompression and transforaminal lumbar fusion. Chart notes from May 22, 2006 state that the patient continues to have pain in his back. The injections did not help. The physician recommended cardiac clearance and began pursuing precertification of the L3-4 surgical intervention. The most recent progress notes, dated January 2, 2007, state that the injured employee continues to try to get his diabetes and hypertension under control prior to proceeding with surgery for the L3-4 level. He stated that his doctor will release him next week. It should be noted that the above reviewed chart notes consistently list physical examination findings regarding the lumbar spine and lower extremities that are within normal limits.

ANALYSIS AND EXPLANATION OF DECISION: The most recent medical records fail to document positive examination findings regarding the injured employee's lower extremity neurologic status. The most recent electrodiagnostic studies do not document acute radiculopathy, only evidence of old S1 radiculopathy. The study makes no mention of neuropathy at the L3-4 level. In addition, the records fail to document that the patient has current instability at the L3-4 level for which a fusion procedure may be considered. Imaging from 2005 demonstrated a broad 2.0 mm disc protrusion/herniation at L3-4 with mild central canal stenosis and mild bilateral neural foraminal narrowing. It should be emphasized that the stenosis was found to be mild. These stenotic findings have not produced current neurologic deficits in the patient's lower extremities according to the most recent documentation. The records now show that the patient has undergone physical therapy and lumbar epidural steroid injections. However, without evidence of positive neurologic findings, frank neural compromise upon imaging, electrodiagnostic evidence of current radiculopathy, and instability demonstrated on x-rays, the requested surgery is not indicated.

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:

- X ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCP- 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

GUIDELINES / REFERENCES: LUMBAR DECOMPRESSION AND FUSION

According to the ACOEM Guidelines, page 307, "patients with increased spinal instability (not work-related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion." Additionally, the guidelines state that there is no scientific evidence about the long-term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as 'much better' in the surgical group versus 14% 'much better' in the nonfusion group (a 15% greater chance of being 'much better') versus a 17% complications rate (including 9% life-threatening or reoperation).

According to the ACOEM Guidelines, page 305, referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short- and long-term from surgical repair; and failure of conservative treatment to resolve disabling radicular symptoms.

According to the Official Disability Guidelines in Worker's Compensation, fusion is not recommended in the absence of fracture, dislocation, or instability. There is no scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion is effective for treatment of any type of low back problem, in the absence of spinal fracture or dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. It is important to note that, although it is being done, lumbar fusion for general back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the fusion group versus a 17% complication rate (including 9% life threatening or re-operation). Another clinical trial found that the success rate of lumbar fusion was less than or equal to noninvasive therapy -- excercises for three weeks and a lecture.