

P-IRO Inc.

An Independent Review Organization

1507 Frontier Dr.
Arlington, TX 76012

Phone: 817-235-1979

Fax: 866-328-3894

DATE OF REVIEW: MAY 31, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Transforaminal lumbar interbody fusion with pedicle screw fixation and one-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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-ray, xx/xx/xx

Office note, Dr., xx/xx/xx

Office note, Dr., 04/29/02

Office note, Dr., 05/13/02

MRI, 06/04/02 and 07/06/04

Peer reviews, 06/04/03, 01/15/04, 03/08/04, 03/06/07 and 03/23/07

Office note, Dr., 12/12/03, 06/09/04 and 09/08/04

scan, 08/18/04

Letters, Dr., 09/27/04 and 03/14/05

Study, 01/12/05

Left lumbar epidural steroid injection noted, 03/02/05

Office notes, Dr., 04/26/05, 09/01/05, 10/12/05, 11/28/05, 01/09/06, 06/15/06 and 09/14/06

Lumbar epidural steroid injection, Dr., 11/10/05 and 12/12/05

Scan, 09/05/06

Office notes, Dr., 10/30/06, 11/27/06, 02/19/07 and 04/25/07

MRI, 02/13/07

Letters Dr., 03/14/07 and 04/19/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male forklift mechanic/stocker who lifted cat litter on xx/xx/xx and reported the acute onset of low back pain. The xx/xx/xx Lumbar spine x-rays showed deformity of the anterior superior end plate of L1 which might represent old trauma or degenerative change. The claimant treated with Dr. on xx/xx/xx for right sided back pain which radiated to his buttock. Exam findings revealed tenderness to palpation and spasm from T12 to L3 on the right and a negative straight leg raise. Impression was lumbar strain. Skelaxin, Vicodin, physical therapy and light duty was recommended. The claimant was a smoker.

On xx/xx/xx, the claimant saw Dr. for right upper and mid back complaints. Exam findings revealed a limp, able to toe heel toe walk, no spasm and flexion to within 12 inches of touching his toes. Seated bilateral straight leg raises produced no obvious discomfort. The claimant was overweight. There were no neurological findings. Impression was spondylogenic cervicothoracic spine pain, subacute and anatomic etiology undetermined. Physical therapy, not able to work his pre-injury job and medications were recommended. On 05/13/03, the claimant began treating with Dr. of chiropractics who recommended an MRI.

The 06/04/02 lumbar MRI showed a significant compression deformity in the lower thoracic region at T12 level. There was a minimal bulge of one of the intervertebral discs in the mid thoracic level at approximately T6 or T7 which was noted to produce little if any spinal canal compromise. On 12/12/03, Dr. saw the claimant for his persistent mid lumbar spine pain. The claimant noted paresthesias radiating across both sides and a burning pain. The claimant reported his legs felt weak and that he had gained 100 pounds since his injury. Recommendation was weight reduction and Topamax. A peer review was completed on 01/15/04 and denied the request for thoracic MRI due to the xx/xx/xx MRI showing minimal degenerative disc disease and no canal compromise. In addition, there were no radicular complaints. A 03/08/04 peer review denied the request for a 3-D CT scan due to no clinical signs of disc herniation.

Dr. saw the claimant on 06/09/04. The claimant's symptoms were unchanged. Impression was myofascial pain syndrome of the thoracic and lumbar spine. The 07/06/04 thoracic MRI showed areas of mild discogenic change through out the thoracic spine which produced areas of mild central canal stenosis. The 08/18/04 lumbar sacral CT scan showed a 3 millimeter left paracentral combined disc protrusion with spondylosis, predominately "hard disc" producing moderate ventral dural deformity above the origins of the S1 root sleeves and left 8 millimeter residual midsagittal spinal diameter. There was also a central 2 millimeter disc protrusion at L4-5 with mild ventral dural deformity and 9 millimeter residual midsagittal spinal diameter.

On 09/08/04, Dr. noted the results of the 08/18/04 CT scan of the lumbar spine. On 09/27/04, Dr. authored a letter stating that the claimant's condition was related to the xx/xx/xx injury and that he disagreed with the findings of the designated doctor examination and with the impairment rating of 5 percent. Dr. felt the claimant was not at clinical maximum medical improvement; however, Dr. felt that the claimant was at statutory maximum medical improvement and recommended lumbar epidural steroids and physical therapy.

A 01/12/05 electromyography showed evidence of chronic right L4 radiculopathy. The claimant underwent a 03/02/05 left L5-S1 epidural steroid injection. Dr. of pain management saw the claimant on 04/26/05 for low back and bilateral leg pain to his heels, right greater than left. The claimant reported the 1/05 epidural steroid injection provided 12 hours of relief. Exam findings revealed a positive straight leg raise on the right at 50 degrees, tenderness and sensory loss at the right L5-S1. Dr. reviewed the 08/18/04 lumbar CT scan. Diagnosis was L4-5, and L5-S1 disc protrusions with lower lumbar radiculopathy from lifting injury of xx/xx/xx. Additional diagnosis was chronic myofascial pain syndrome. Dr. recommended Neurontin, narcotics and lumbar epidural steroid injections.

On 09/01/05, Dr. saw the claimant in follow-up and the claimant reported sleeping 16 to 18 hours a day. Dr. discontinued the Flexeril, Skelaxin and Robaxin. Dr. increased his MSContin. On 11/10/05, the claimant underwent a lumbar epidural steroid injection at L4-5. The claimant reported to Dr. on 11/28/05 no relief from the first epidural. Dr. performed a second epidural steroid injection on 12/12/05 at L3-4. On 05/01/06, Dr. recommended a lumbar CT scan due to the claimant's persistent back complaints. On 06/15/06, the claimant reported to Dr. that he was losing feeling in his legs. Reflexes showed knee extensors of 4/5, quad atrophy of 5 centimeters circumference difference when compared to the left side and sensory loss at L2-4 dermatomes.

The 09/05/06 CT of the lumbar spine showed a posterolateral and left-sided protruding disc associated with osteophytic spurring that involved L5-S1 with asymmetric foraminal stenosis on the left. The canal diameter was considered at the lower limits of normal. There was milder posterolateral L4-5 disc bulge/protrusion with the canal diameter which was also considered at the lower limits of normal. Chronic appearing limbus vertebra involves the anterior superior corner of L1 was noted. On 09/16/06, Dr. reviewed the results of the lumbar scan and referred the claimant to Dr.

Dr. saw the claimant on 10/30/06 for 90% back pain and very little leg pain. The claimant was taking Zoloft, Vicodin, Xanax and Lithium Exam findings revealed no spasm or tenderness, able to heel toe walk and lumbar extension caused back pain. Straight leg raise was to 90 degrees bilaterally. Strength was 5/5 to his bilateral lower extremities. Dr. reviewed the 09/05/06 lumbar CT scan and felt that it showed at L5-S1 findings consisted with a protruding disc, osteophyte ridge located and to the left which appeared to outline the component of the protruding disc, and at L4-5 a mild posterior central bulging disc. Impression was discogenic low back pain. Dr. recommended an MRI and planned to review his electromyography.

The 02/13/07 MRI of the lumbar spine showed a large disc protrusion at L5-S1 and a small central broad based disc protrusion at L4-5. On 02/19/07, Dr. documented that he had suspected all along that the claimant had a disc herniation causing him discogenic

low back pain that was not initially diagnosed early on in the stages of his injury. The claimant admitted to being depressed. Exam findings revealed positive straight leg raise bilaterally at 45 degrees reproducing low back and leg pain, hypoactive bilateral Achilles reflex, and unable to bend over and grab his knees. Dr. noted that the radiographs had shown a central disc herniation at L5-S1 which was the etiology of his symptoms and that the CT scan showed intervertebral disc displacement disorder at L5-S1. Impression was large central disc herniation. Dr. recommended a lumbar laminectomy at L5-S1 with a minimally invasive transforaminal lumbar interbody fusion with placement of pedicle screw fixation. A 03/06/07 peer review denied the fusion due to no findings of instability, findings of obesity and some concern regarding psychiatric issues and relatedness of the claimant's symptoms to the work injury.

A second peer review completed on 03/23/07 denied the requested surgery due to no clinical indications for a fusion and due to the claimant's history of psychiatric disease. On 04/25/07, Dr. saw the claimant for back and leg pain. Dr. opined that this was not a degenerative process but was a work related injury in which the claimant had a disc herniation. Dr. commented that the claimant had a large central disc herniation and by removing the disc herniation alone would cause some instability in his lower back, and his lumbar spine should be stabilized at the time of its removal. Dr. recommended a lumbar laminectomy at L5-S1 level with excision of disc herniation with minimally invasive translumbar interbody fusion with placement of pedicle screw fixation. Dr. noted that the claimant had not been hospitalized for any psychological illnesses and did not exhibit any secondary behaviors.

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

After a careful review of all medical records, the Reviewer's medical assessments is that it is not possible to state that the degenerative disc change and protrusion seen at L5-S1 is the cause of this claimant's symptoms. It must be noted that disc abnormalities at this level do not correspond with his electrodiagnostic abnormality which was the level above at L4. It does not appear that he has been evaluated by a discogram with a comparison level or two to see if this is truly his pain generator.

Taking all of this into consideration, particularly considering this claimant's significant youth, the Reviewer does not believe that the current records support the medical necessity of transforaminal lumbar interbody fusion with pedicle screw fixation at the L5-S1 level.

Official Disability Guidelines, Treatment in Workers' Comp, Updated 2007

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
 - Official Disability Guidelines, Treatment in Workers' Comp, Updated 2007
- 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)