



- MD medical records [2/6/07, 2/27/07] as well as MRI [8/4/07]; EMG and Nerve Conduction Study [8/28/06]; Upper & Lower Extremity Potential Study [9/6/06]; Spine & Rehab Evaluation [12/19/06]; Pre-Authorization request [3/12/07]; Request for Reconsideration [3/20/07].

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient was first seen having reported an injury when he was standing by a curb and was hit by a car and was apparently thrown into the air injuring his lower back, neck and both knees. He was complaining of pain in his left neck, lower back and both knees. X-rays of his cervical spine and lumbar spine showed no fractures. Knee x-rays were also negative. The initial diagnosis was cervical sprain, trapezius strain, lumbar contusion and knee pain. He showed restricted lumbar range of motion but had symmetrical reflexes in the lower extremities. He was followed at Clinic for several visits and physical therapy was started in July 2006. He had an MRI of the left knee done 8/2/06 showing medial meniscal tear, a small joint effusion and right knee MRI showed degenerative change in the posterior horn of the medial meniscus.

He was sent to Spine Clinic 7/26/06 with complaints of neck pain, lower back pain and pain in both knees. The examination demonstrated restriction of lumbar range of motion, symmetrical reflexes. The diagnosis by Dr., DC indicated cervical spine strain, displacement lumbar disk, and knee strain and sprain as well as muscle spasm. Physical medicine treatments were recommended.

On 8/3/06 he had cervical MRI showing multiple anomalies not germane to this request. Lumbar MRI scan showed L4-5 bilateral foraminal narrowing and at L5-S1 there was a 3mm left parasagittal subligamentous disk herniation with mild bilateral foraminal encroachments. He was treated with physical medicine treatments at the Spine and Rehab Clinic on multiple occasions with exercises and modalities in August 2006.

On 8/26/06 he underwent EMG nerve conduction studies done by Dr. These showed evidence of bilateral C6 and C7 acute radiculopathy. He had indication of median nerve compression in both wrists. The lower extremities showed evidence of acute irritability and bilateral L3-L4-L5 and S1 nerve roots. He continued follow up at the Spine Clinic. He was seen by Dr. on 8/10/06 and 12 sessions of therapy were felt to be medically needed as well as EMG of the lower extremities.

He continued with physical medicine treatments and on 8/25/06 he was complaining of pain in the left neck and sharp lower back pains. He had an EEG on 9/6/06 by Dr. for postconcussive syndrome. He was found to have a mildly abnormal EEG.

On 9/7/06 case management conference note is present from Dr. at which time the claimant's cervical and lumbar MRI scans were reviewed by Dr., a board certified radiologist and Dr. an orthopaedic surgeon. Lumbar MRI was felt to

show a high intensity zone at L5-S1 without any other significant abnormalities at other levels. It was felt that the patient had an HMP at that level. Physical medicine treatments were continued through September 2006.

On 9/14/06 the claimant was seen by Dr. for pain management evaluation. Diagnoses included herniated cervical disk at C3-4, herniated lumbar disk at L5-S1 and a torn meniscus of the left knee. Request was placed for lumbar spine epidural steroid injections. On 9/13/06 he had a physical performance evaluation and was unable to complete many of the tasks due to complaints of back pain.

On 4/20/07 the patient was seen for a required medical exam by Dr. who felt he had not reached maximal medical improvement. He thought the patient might require surgical intervention for his meniscal tear and/or his neck and lumbar problems.

He had a lumbar epidural steroid injection done on 10/20/06. MRI scan dated 8/24/06 showed disk dessication and bulging at L5-S1 with mild facette degenerative changes. MRI of the left knee showed no evidence of internal derangement but he did have degenerative meniscal changes.

On 9/29/06 he had a required medical exam by Dr.. He diagnosed moderate degenerative changes of the cervical spine, moderate degenerative changes of both knees, diffuse pain complaints out of proportion to the known mechanism of injury. He also suggested the patient demonstrated signs of chronic pain behavior and functional overlay and noted he had pending litigation and was on Workers' Compensation. He felt that due to the patient's pending litigation and his failure to improve with treatment, etc. that prognosis was very limited. On 10/12/06 Dr. saw the patient back status post his first epidural. He noted reduction in his back pain and also some radicular symptoms in the left leg. He noted positive straight leg raising of the right. He recommended proceeding with repeat epidural steroid injection.

On 9/12/06 the patient had a behavior health assessment at Spine and Rehabilitation Clinic by MA, where psychological testing revealed increased scores for pain and anxiety on the Beck Inventories. The patient complained of chronic pain interfering with his lifestyle. He was felt to have major depressive disorder single episode not mild and pain disorder associated with both psychological factors and a general medical condition. Problems related to the injury included severe pain, depression, anxiety, difficulty performing ADL, sleep disturbances, difficulty dealing with stress and inability to work. Individual therapy sessions were recommended regarding psychotropic medications, stress management and treatment of his anxiety and depression. There were no records of any psychological treatments having been rendered.

Records from Dr. 's office, orthopaedic surgery, indicate the patient was seen on 2/6/07. He was complaining of chronic neck and bilateral arm pain, lower back pain and left leg pain and some right leg pain. He apparently had surgery on one

of his knees. He reported history of having been struck by a car. He reviewed the patient's radiographic studies. Lower back exam revealed paravertebral muscle spasm, sciatic notch tenderness, limited range of motion, a positive Flip test, bilaterally positive Lasegue's test, a decreased left ankle jerk, absent posterior tibial tendon jerks, paresthesias at L5 and S1 nerve root distribution on the left and mild weakness of the left gastrocnemius. His assessment was lumbar loss of motion, segment integrity with left lower extremity radiculopathy and herniated nucleus pulposus as well as neck pain with upper extremity radiculopathy and diskogenic symptoms. He discussed surgical intervention. X-rays were also reviewed of the lumbar spine including flexion extension views, which revealed bone on bone at L5-S1 with spondylosis and stenosis and facet subluxation as well as foraminal stenosis and retrolisthesis of 6mm of L5 on S1 in extension, which corrected to 0 degree on forward flexion.

On 2/27/07, Dr. saw the patient again and reviewed his findings. He felt that at L5-S1 there was a non-contained disk herniation with nuclear extrusion and contained disk herniations at C3-4, C5-6 and C6-7. He suggested provocative cervical discography. He discussed surgery of the lumbar spine and recommended proceeding with L5-S1 fusion.

A pre-authorization request was sent by Dr. 's office to the insurance carrier requesting inpatient lumbar spine including lumbar laminectomy, discectomy, arthrodesis using cages, posterior instrumentation, implantation of a bone growth stimulator.

On 3/19/07 Dr. recommended non-authorization to the procedure. It was his opinion that the level of service appeared to be excessive and that the proposed procedure would place more stress on the adjacent degenerative L4-5 disk space leading to long-term complications.

Dr. recommended non-authorization based upon lack of documentation of conservative care and lack of documentation regarding outcome of psychosocial evaluation.

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

**BASED UPON *ODG-TWC GUIDELINES* THE PATIENT DOES MEET PATIENT SELECTION CRITERIA IN THAT HE DOES DEMONSTRATE EVIDENCE OF SEGMENTAL INSTABILITY WITH 6MM OF TRANSLATION OF L5 ON S1 IN EXTENSION. HE ALSO HAS MRI EVIDENCE OF DEGENERATIVE DISK CHANGES AT L5-S1 AND SOME DEGENERATIVE SPONDYLOSIS OF THE L5-S1 LEVEL. HE HAS UNDERGONE CONSERVATIVE TREATMENT FOR OVER SIX MONTHS AND HAS FAILED PROLONGED PHYSICAL THERAPY AND EPIDURAL STEROID INJECTIONS.**

HOWEVER, UNDER PREOPERATIVE SURGICAL INDICATIONS RECOMMENDED IT STATES CLEARLY THAT PSYCHOSOCIAL SCREENING MUST BE PERFORMED WITH CONFOUNDING ISSUES ADDRESSED. THERE IS NO DOCUMENTATION IN THE RECORDS THAT THE CONFOUNDING ISSUES OF DEPRESSION, ANXIETY AND PENDING LITIGATION HAVE BEEN ADDRESSED. FURTHER SUPPORT FOR EVALUATION OF THE PSYCHOLOGICAL AND OTHER CONFOUNDING FACTOR IS AVAILABLE FROM *WASHINGTON STATE DEPARTMENT OF LABOR AND INDUSTRIES GUIDELINES FOR LUMBAR FUSION*. THE REPORT INDICATES THAT THE PSYCHOSOCIAL FACTORS SUCH AS HIGH DEGREE OF SOMATIZATION ARE ASSOCIATED WITH POOR OUTCOMES. THESE FACTORS NEED TO BE ADDRESSED AND AN OPINION FROM A QUALIFIED MENTAL HEALTH PROFESSIONAL NEEDS TO BE WRITTEN REGARDING THE ADVISABILITY OF PROCEEDING WITH SURGERY.

**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
  - \* *WASHINGTON STATE DEPARTMENT OF LABOR AND INDUSTRIES GUIDELINES FOR LUMBAR FUSION*
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)