



DATE OF REVIEW: 05/15/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of a L4-5 decompression with transforaminal lumbar interbody fusion, with a 3-day inpatient length of stay.

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

Texas Licensed Orthopedic Surgeon and is currently listed on the TDI/DWC ADL list.

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)

The previously denied request for a L4-5 decompression with transforaminal lumbar interbody fusion, with a 3-day inpatient length of stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Office notes, Dr., 12/20/05, 12/27/05 and 1/3/06
- Office note, Dr., 2/1/06
- Lumbar spine MRI without contrast, 2/7/06
- Office note, Dr., 2/23/06
- Note, PA for Dr., 3/1/06
- Lumbar myelogram and post CT, 8/16/06
- Office note, Dr., 9/12/06
- Office note, Dr., 9/19/06
- Peer reviews, 3/8/07 and 4/9/07

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: While hanging a guardrail, slipped and fell in a hole.

Diagnosis: Sprain/strain, right hip/thigh.

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

Summary of clinical course:

The patient is a male who developed a pulling sensation in the right proximal thigh after falling into a hole. He was diagnosed with a sprain/strain in the right hip / thigh and was treated conservatively with medications, ice, heat, range of motion and stretching through December 2005.

The patient presented to Dr. for worsening pain, which included pain around the entire proximal thigh radiating up his lateral thigh to his hip and occasional numbness going down his leg. He was referred to and seen by Dr., an orthopedic surgeon, on 2/1/06; Dr. indicated that he had evaluated the patient, at which time, the patient was diagnosed with a lumbar strain and sent for therapy and given anti-inflammatories. During the 2/1/06 visit, the patient reported continued discomfort in his leg with minimal improvement and continued burning pain down his leg, now progressing below the knee along the anterior lateral aspect of the leg despite Relafen. The examination of the bilateral lower extremities demonstrated subjective burning dysesthesias into the lateral thigh and into the anterior medial leg. Reflexes were one-plus and symmetric. A lumbar MRI, Medrol Dosepak, Norco, off-work, and hold therapy were recommended.

An MRI of the lumbar spine performed on 2/7/06 showed degenerative disc disease with left lateralizing disc bulge at L4-5 resulting in moderate to severe stenosis of the left anterolateral recess and L4 neural foramen and mild central canal stenosis at this level; mild degenerative disc disease at L3-4 with mild left L3 foraminal stenosis without significant spinal canal stenosis or disc herniation; and mild edema associated with the right L4 superior articular process, probably related to facet degeneration rather than acute traumatic injury.

Dr. evaluated the patient for worsening symptomatology that was mostly right-sided and pain on the inside of his legs radiating to the testicles. Straight leg raise was positive on the right for posterior thigh and popliteal type pain, and there was a positive straight leg raise on the left, but not as significant on the right. X-rays and MRI were reviewed and showed evidence of disc degeneration and disc herniation. The patient was sent for a surgical referral.

PA for Dr., saw the patient on 3/1/06, noting low back and bilateral lower extremity pain (greater on the right) and quite a bit of testicular pain. He declined epidural steroid injections, stating he wanted something more definite to be done. There was quite a bit of tenderness to palpation in the lumbar spine, especially over the lumbosacral junction and into his right sciatic notch, a positive straight leg raise on the right side, and diminished strength in his right hip flexors.

A lumbar myelogram and post CT on 8/16/06 demonstrated a small disc protrusion to the right, bilateral facet arthrosis at L3-4, a small broad based disc protrusion without focal central stenosis, left paracentral disc and spur at L4-5 with spurring into the left L4-5 neural foramen causing mild central stenosis, left lateral recess stenosis, and left foraminal compromise.

On 9/12/06, Dr. saw the patient, apparently for a lumbar discogram; however, only page one of the report was provided, which noted low back pain with numbness and tingling in the patient's legs and back and leg pain, cough, sneezing, and intermittent staining of his shorts with stool.

As of the 9/19/06 visit, Dr. indicated that discography on 9/12/06, showed significant concordant pain reproduction at L3-S1. The patient characterized the pain as approximately 60 percent low back pain and 40 percent lower extremity pain. There was quite a bit of tenderness in the lumbar region and some into both sciatic notches and he was neurologically intact on examination. He was to consider pain management modalities such as a spinal cord stimulator.

The requested L4-5 decompression with transforaminal lumbar interbody fusion with a three-day length of stay was denied on two reviews dated 3/8/07 and 4/9/07.

Pre-Operative Surgical Indications Recommended, as per the Official Disability Guidelines:

Pre-operative clinical surgical indications for spinal fusion 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-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography 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.

Rationale / Source of opinion:

This male has been referred for lumbar fusion at L4-5. Within the records, this patient's symptoms appeared to include a combination back pain and various degrees of leg pain, as well as pain reportedly radiating to the anteromedial thighs. Physical examination findings described tenderness but did not appear to describe a distinct neurologic deficit. Imaging studies documented a combination of degenerative change with some degree of neuroforaminal compression at L4-5, although it did not appear to be profound. Lastly, discography from September 2006 described concordant pain at virtually all levels tested. Based on that examination, there was no recommendation made for any surgery under those circumstances.

In this reviewer's opinion, there was no indication for the proposed fusion surgery at L4-5. This reviewer would submit that this patient's subjective complaints of leg pain did not fit a typical dermatomal pattern for L4-5 neural compression.

Furthermore, his discography was reportedly concordant at all levels, which suggested that it would not be considered entirely reliable in determining the pain generator. Lastly, there was no indication for progressive neurologic deficit or demonstrable instability at this level that would suggest surgery as being indicated.

For all of the above stated reasons, this reviewer cannot recommend the proposed surgery as being either reasonable or medically necessary.

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. Chapter 12, pages 307-310.

- 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.
Low back chapter.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND 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).

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