

# Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Phone: 817-235-1979

Fax: 817-5489-0310

**DATE OF REVIEW:** MAY 29, 2007

**IRO CASE #:**

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

Laminectomy/discectomy L4-S1 lateral fusion / posterior segmental instrumentation / internal bone growth stimulator with two day length of 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**

MRI, 10/09/06

EMG/NCV, xx/xx/xx

Office note, Clinic, 10/25/06

Office notes, Dr., 10/31/06, 01/12/07 and 03/13/07

Designated examination, Dr., 11/01/06

Functional capacity evaluation, 11/01/06

Office note, Dr., 11/13/06, 12/01/06, 01/05/07, 02/28/07 and 04/25/07

Epidural steroid injection noted, 12/22/06

Notice of dispute of diagnosis of spondylosis, 12/27/06

Peer review, Dr., 01/22/07

Letter of clarification, Dr., 03/13/07

Notice of dispute, 03/13/07

HEALTH AND WC NETWORK CERTIFICATION & QA 8/23/2007

IRO Decision/Report Template- WC

Radiology peer review, 03/19/06  
Medical review, Dr., 03/19/07  
Medical review, Dr., 03/21/07  
Letters, 03/21/07, 04/17/07 and 04/23/07  
Request for surgery, Dr., 04/13/07  
RME, Dr., 04/23/07  
Letter from an Attorney, 05/17/07  
Note, 02/07/07  
Note, Dr. 11/08/06

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female injured on xx/xx/xx when she fell and injured her low back, right ankle and her knee. The ankle and knee are not concerns for this dispute.

The 10/09/06 MRI of the lumbar spine showed that L1-2, 2-3 and 3-4 were normal. At L4-5 there was an annular disc bulge flattening the thecal sac as well as bilateral facet arthrosis with thickening of the ligamentum flavum and mild bilateral foraminal encroachment. The L5-S1 disc was desiccated and there was a small herniation flattening the thecal sac, facet arthrosis and mild bilateral foraminal narrowing. A xx/xx/xx EMG/NCV was performed for complaints of back and bilateral leg paresthesia to the feet. The reading was normal.

The claimant entered a pain management program with Dr. On the 10/31/06 examination there was a positive right back and leg pain with straight leg raise. Reflexes were symmetrical and light touch was intact.

On 11/01/06 Dr. saw the claimant for a designated examination. She reported low back pain with weakness on the legs. On examination the posture was stooped. There was pain of the thoracic and lumbar spine with light touch and pain with axial loading. On examination with pinwheel, there was a non anatomical pattern of decreased sensation. An FCE on the same day found invalid effort with the ability to work less than sedentary above the waist and inability to work below the waist.

The claimant then came under the care of Dr. on 11/13/06. On examination there was spasm and pain with any motion. The extensor hallucis longus were felt to be 4/5 in strength. Dr. recommended epidural steroid injection. She had two injections without any long term benefit. When Dr. saw the claimant on 01/05/07 she had reported positive straight leg raise at 45 degrees and decreased sensation in L5-S1. A two level decompression and fusion was recommended.

On a record review by Dr. dated 01/22/07, it was felt that she did not need further treatment. On a radiology peer review of the MRI from 10/06, the radiologist felt that there was degenerative change at L5-S1 without significant impingement. Peer reviews by Dr. on 03/19/07 and Dr. on 03/21/07 also felt the claimant did not have surgical indications or need for a psychiatric evaluation.

The claimant was seen on 04/23/07 by Dr., Orthopedist, for an RME. The claimant reported bilateral lower extremity numbness, tingling and giving way. On walking the claimant remained hunched. She was tender from the inner scapular area all the way down to the gluteal cleft. Superficial tenderness was also noted. The claimant

reportedly would not flex or extend and minimally toe and heel rose. There were no tension signs but there was breakaway weakness. Sensory was normal. Signs were four of five. Dr. did not feel the claimant was a surgical candidate.

The claimant returned to Dr. who still felt she needed surgery based on his examination of extensor hallucis longus weakness and positive straight leg raise with decreased ankle reflexes. He has made a third level appeal for surgery.

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

The above would not be found to be reasonable or necessary. The medical documentation documents this diagnosis as a lumbar strain and pre-existing degenerative condition of the back. MRI on 10/9/06 showed degenerative changes. The claimant does not have consistent neurological deficits on examination. Her MRI does not show significant neural impingement. There is no evidence of spinal instability. Of concern is the fact that the claimant was noted to display symptom magnification by Dr. on 11/01/06 and significant were noted by Dr. on 04/23/07. This would suggest that she may have a less than optimal surgical outcome. After a careful review of all medical records, the Reviewer's medical assessment is that the laminectomy/discectomy and fusion L4-S1 cannot be recommended

Official Disability Guidelines Fifth Edition Treatment in Worker's Comp 2007 Updates; Low Back-Fusion

**Pre-Operative Surgical Indications Recommended:** 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; & 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.

**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 Fifth Edition Treatment in Worker's Comp 2007 Updates; Low Back-Fusion
- 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)