

I-Decisions Inc.

An Independent Review Organization

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

ANTERIOR INTERBODY FUSION, FIXATION AND DISSECTOMY AT L3-4, RETROPERITONEAL EXPOSURE, BONE GRAFT, ALLOGRAFT WITH 2 DAYS INPATIENT STAY AND CYBERTECH TL50 BACK BRACE FOR USE POST OPERATION.

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 Lumbar spine, 02/01/06
EMG/NCV, 04/20/06
Psych testing, 07/30/06
Physical performance evaluation, 09/29/06
Impairment rating, 09/29/06
Report of medical evaluation, 09/29/06

Group SOAP notes, 01/19/07, 01/22/07, 03/14/07, 04/09/07, 05/21/07, 06/26/07, 07/11/07, 08/02/07, 08/24/07
X-rays exam report, 01/19/07
Office notes, Dr., 05/07/07, 07/16/07
Lumbar discogram, 07/03/07
Post CT, 07/03/07
Pre-authorization for surgery, 07/19/07
Review, Dr. 08/07/07
Review, Dr. 08/20/07
Office note, Dr. 08/29/07, 08/24/07
Dr. 11/01/06
Adverse Determination Letters, 08/07/07, 08/20/07
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Fusion & back brace)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male who slipped on ice and hit his back on a concrete curb on xx/xx/xx. He was reportedly diagnosed initially with a lumbar strain, sacroiliac disorder and radicular pain. A lumbar MRI performed on 02/01/06 showed a small annular tear/fissuring in the right posterolateral corners of L3-4 and L5-S1 with minimal annular bulging. EMG/NCV studies on 04/20/06 demonstrated a post-traumatic lumbar spine intervertebral nuclear destruction with discogenic pain. Dr. was noted to have seen the claimant on 06/19/06 and diagnosed the claimant with an L3-4 and L4-5 discal tear and L3-4 and L5-S1 disc herniations. He declined injections and amitriptyline was ordered. He attended work hardening between 06/23/06 and 08/11/06.

A psychological evaluation on 07/30/06 noted the claimant to have depression and anxiety which was not limiting his work with his physicians in developing and implanting treatment plans. The therapist indicated that it was very important to reassess these issues and support him in managing them as the situation developed, but that he was very appropriate for surgical intervention.

A physical performance evaluation was obtained on 09/29/06 noting the claimant's continued low back pain, paresthesias and right lower extremity weakness. His job reportedly fell within the light to medium level with his lifting status at medium. His study results did not meet the requirements, safety or performance ability to do his job safely, effectively or confidently without restrictions. Injections, a psychological evaluation and multi-disciplinary chronic pain management program were advised. An impairment rating exam that day showed positive Minor's sign, positive straight leg raise, vertebral fixations, spasm, muscle restrictions, a raised hip on the left and head forward posture, reflexes on the right at 1 plus and 4/5 strength of the right lower extremity. He was not determined to be at Maximum Medical Improvement and had an estimated lumbosacral rating of 5 percent.

Dr. evaluated the claimant on 11/01/06 at which time the examination showed a slow, antalgic gait, 1 plus reflexes bilaterally and a positive supine straight leg raise at 75 degrees bilaterally. The claimant reported that a pain management physician recommended injections in his hip rather than his back. Dr. did not feel the claimant was at Maximum Medical Improvement and recommended pursuing the treatment options per his treating physician.

A hand written report of lumbar spine x-rays of 01/19/07 noted a hypolordotic curvature, mild small osteophytic formation and well maintained disc height. Dr. evaluated the claimant on 05/07/07 noting persistent unremitting low back pain with locking up and some intermittent giving way of the right lower extremity. Flexion/extension x-rays taken on 05/07/07 showed good alignment of the five lumbar vertebrae, adequate maintenance of the disc space height and no real significant abnormalities. The examination was negative and lumbar syndrome, spondylosis at L3-4 and possible discogenic pain were diagnosed. Dr. ordered a lumbar discogram and stated the claimant was a surgical candidate. The claimant treated with electrical stimulation between 01/22/07 and 08/24/07.

A lumbar discogram performed on 07/03/07 showed: L2-3: no pain or pressure. The radiographic appearance showed a partial annular fissure without extension to the superficial annular margin; 10/10 concordant middle low back pain in the normal spot at L3-4. There was anterior and circumferential posterior fissuring lateralized to the left with focal epidural contrast extravasation. L4-5 showed 10/10 concordant middle low back pain radiating to the groin bilaterally. There was minimal partial fissuring along the most inferior disc margin. L5-S1 showed only mild pressure, but no pain and a normal radiographic appearance. The post discogram CT showed similar findings. An anterior discectomy, interbody fusion, interbody fixation with STALIF at L3-4 and a 1-2 day stay was recommended with a preoperative psychiatric evaluation. The surgical request was denied on two reviews; 08/07/07 and 08/20/07 and are currently under dispute.

Dr. FRCP saw the claimant on 08/29/07 noting examination findings of a lumbar antalgia to the right, a normal gait, extensor and lateral flexor strength of +2/5 with pain in L3, L4 and L5 on the right. He showed emotional distress, frustration, depression, and anxiety. Continuation of Hydrocodone was ordered.

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

The case under review is a xx-year-old male reportedly injured in of xxxx when he had a slip and fall event onto a concrete curb. An MRI of 02/01/2006 suggested small annular tearing or fissuring at L3-4 and L5-S1 with some minimal bulging. These changes would be incidental in a xx-year-old spine. Plain films from January 2007 revealed a hyperlordotic curve and some small osteophytes, again, incidental findings. A discogram of July 3, 2007 revealed two levels of "concordance" with 10/10 pain both at L3-4 and L4-5. There were some degenerative changes with fissuring at L3-4, L4-5, and L5-S1. An L3-4 fusion has been recommended as well as a Cybertech thoracic lumbosacral orthosis.

Based on all of the information available, I would not recommend the proposed procedure or brace in this specific claimant's management. By way of identification of pain generators, it would appear that there are two different levels, which are positive on the discogram, not just the single level proposed for surgery. There is no documentation of instability or nerve root compression. The discographic data reveals subjective complaints at two levels and degenerative disk changes at three levels, as such, spine pathology is not simply limited to two levels. Since this claimant does not meet the ODG guidelines for fusion, then there would be no need for any form of postoperative back support.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Low Back-Fusion & back brace)

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should 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-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI 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. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

Milliman Care Guidelines, 11th Edition, Inpatient and Surgical Care.

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
(PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)