

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
**7502 GREENVILLE AVENUE**  
**SUITE 600**  
**DALLAS, TEXAS 75231**  
**(214) 750-6110**  
**FAX (214) 750-5825**

---

Notice of Independent Review Decision

**DATE OF REVIEW:** February 13, 2008

**IRO CASE #:**

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

360° L4-S1 spinal surgery and Cybertech TLSO back brace to include CPT codes 22558, 22585, 64999, 22851, 63047, 63048, 22612, 22614, 22842, 20930, 20936, 20938, 38220, and L0637.

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

Board Certified Orthopedic Surgery; American Academy of Orthopedic Surgeons

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Medical records from the Carrier include:

- Employers First Report of Injury or Illness
- Chiropractic, 04/12/07, 04/13/07, 04/14/07, 04/16/07, 04/18/07, 04/19/07, 04/20/07, 04/23/07, 04/24/07, 04/26/07, 04/27/07, 04/30/07, 05/03/07, 05/08/07, 05/09/07, 05/11/07, 05/16/07, 05/22/07, 05/29/07, 05/30/07, 05/31/07, 06/06/07, 06/14/07, 06/15/07, 06/21/07, 06/25/07, 06/28/07, 07/02/07, 07/03/07, 07/05/07, 07/10/07, 07/12/07, 07/17/07, 07/23/07, 07/31/07, 08/02/07, 08/14/07, 08/15/07, 10/02/07
- Medical Centers, 04/09/07, 04/11/07
- D.O., 04/24/07, 05/15/07, 06/04/07, 06/18/07, 07/13/07, 07/16/07
- 07/16/07, 08/13/07, 10/23/07, 12/27/07
- Ed.D., 11/27/07
- 01/10/08
- Imaging, 04/19/07
- Diagnostics, 07/03/07
- Official Disability Guidelines, 2007

Medical records from the Requestor/Provider include:

- Spine Care, 07/16/07, 08/13/07, 08/20/07, 10/23/07, 12/27/07, 01/08/08
- Center, 11/27/07
- Imaging, 04/19/07
- Diagnostics, 07/03/07

### **PATIENT CLINICAL HISTORY:**

The patient has no prior history of low back difficulties. She had the onset of low back and right lower extremity pain while lifting a heavy pallet of materials with a pallet jack. The pain gradually became worse and was associated with right lower extremity pain, involving numbness and tingling in the dorsum and plantar aspects of the right foot.

The records for review include an initial evaluation at Medical Centers on xx/xx/xx, revealing low back and right lower extremity pain with a normal neuromuscular sensory evaluation, negative straight leg testing, and no objective findings of radiculopathy. The x-rays at Medical Centers were interpreted as normal.

The patient's pain and problems persisted. She failed to significantly respond to epidural steroid injections times three in June and July of 2007.

Neurodiagnostic studies revealed evidence of involvement of the L5 and S1 nerve roots in the right lower extremity with fibrillations in muscles in the right leg innervated by these nerve roots.

An MRI radiology report of the lumbar spine from April 19, 2007 revealed minor changes; that is a bulge at L4-5 and a 2 mm central bulge or protrusion at C5-S1.

A consultation was obtained with, M.D., beginning on xx/xx/xx. Dr. findings noted some weakness of the toe extensors, some altered sensation in the L5-S1 distribution, in conjunction with the abnormal neurodiagnostic study. Dr. has been the only examiner to note these changes in terms of a neuromuscular sensory deficit. However, her pain complaints are those of low back and right lower extremity radiculopathy of an ongoing nature.

At the present time, the patient's medications are multiple Ibuprofens. She has lost some weight, however, was not overweight to start with on height and weight measurements noted.

Dr. has recommended an evaluation of the specific pain generator by a spinal nerve block, however, the results are not recorded in the records reviewed. He has also recommended a CT discogram for this injured worker.

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

In my opinion, this is too short of a time to justify consideration for such an extensive surgical procedure. There is minor anterolisthesis at L4-5 noted on lateral x-rays, however, no obvious instability revealed on lateral x-rays taken in Dr. office. The disc space at L5 is described as decreased and the disc space at L4-5 is described as intact, both levels have area of disc desiccation change. The MRI findings describing the minor bulge at L4-5 and the 2 mm central protrusion at L5-S1 are not clinically significant and do not identify a specific pain generator.

It is my opinion that ODG guidelines require a progressive neurologic deficit to justify low back surgery. In this case, the patient's right lower extremity pain is persistent. She has loss of sensation in the right foot area consistent with nerve root involvement. She may have weakness of the extensors of the right great toe. These findings correlate with the abnormal neurodiagnostic study mentioned above, and therefore, she does have a neurologic deficit. Whether this is progressive or not is difficult to determine, but her pain is significant.

In the absence of instability, I find no justification for an L4-5 and L5-S1 fusion. I realize she does have disc space narrowing at L5-S1, however, the disc space narrowing in my opinion with the findings noted and with the minor abnormalities on the MRI study, do not justify consideration of a surgical procedure that provides only a 27% likelihood of improvement in a workmen's compensation scenario.

Therefore, in summary, it is my opinion that a fusion procedure in this injured worker would be ill-considered and does not satisfy the ODG guidelines.

**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)