

Independent Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

JANUARY 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of transformational lumbar interbody fusion at L4/5 on the right side and L-brace

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

No ODG Guidelines

MRI lumbar spine, 11/11/06

Office notes, Dr. 07/06/07, 09/20/07, 10/22/07

EMG/NCV, 07/24/07

Discogram, 08/11/07

Flexion/extension X-rays, 09/20/07

Notes, 10/08/07, 11/19/07

Case Notes

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured while helping a patient into bed when she developed back and right lower extremity pain.

The 11/11/06 MRI of the lumbar spine showed a small to moderate hemangioma at S2. At L2-3 was a mild left foraminal disc protrusion mildly narrowing the left foramina. The L3-4 and L5-S1 showed mild posterior protrusions mildly impinging the thecal sac and narrowing the lateral recesses of the foramina bilaterally. At L4-5 was a moderate protrusion mildly impinging the thecal sac and narrowing the lateral recesses and both foramina. There was severe bilateral facet hypertrophy at L4-5 and L5-S1, moderate facet hypertrophy at L2-3 and L3-4, moderate disc dessication at L3-4 and L4-5 and annular tears L2 through S1.

On the 07/06/07 visit with the treating physician the claimant reported that her pain was constant. She had been treated with medications, therapy, anti-inflammatory medications and two epidural steroid injections. On examination there was significantly decreased lumbar motion and a left positive straight leg raise. Patellar reflexes were bilaterally decreased. Right extensor hallicus and dorsiflexion strength were 4/5 and there was decreased sensation in L5 and S1.

The 07/24/07 EMG/NCV showed mild chronic re-innervation distal left L5. The right side was not completed. On the 08/11/07 discogram L3-4 negative. At L4-5 she had concordant pain with an annular tear. L5-S1 was negative. The post CT showed that L3-4 was unremarkable. At L4-5 were degenerative annular tear, moderate degenerative facet hypertrophy and moderate right neural foraminal narrowing related to a bulge or protrusion. L5-S1 was normal. The 09/20/07 x-rays of the lumbar spine with flexion/extension showed that there was degenerative disc disease at L4-5 with spurring and no instability. Dr. noted on the 09/20/07 visit that the claimant had increasing with leg weakness that had made her fall. On examination right extensor hallicus longus and dorsiflexion strength were 4-/5. He recommended surgery for fusion at L4-5. The surgery request was denied on peer review.

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

Medical necessity of transforaminal lumbar interbody fusion at L4-5 on the right side with a lumbar brace does not appear to be medically necessary and appropriate.

This is a male who was injured helping put a patient into bed and developed back pain and right lower extremity pain. There is a documented electromyogram and nerve conduction study which demonstrates mild chronic reinnervation distal L5, left sided. The right side was not completed due to discomfort. There is a discogram and a CT scan which demonstrated annular tearing, degenerative facet hypertrophy, neural foraminal narrowing, related to a bulge, and flexion and extension radiographs on 09/20/07 which did not demonstrate any instability and flattening and spurring at the L4-5. Based upon the documentation on 11/19/07, a psychological evaluation was pending, but it was not available for review. The Reviewer does not think that interbody fusion is required or necessary for this claimant. There is no evidence of instability, tumor, or infection. Given this, the Reviewer does not think it is reasonable and appropriate to do fusion surgery in this clinical scenario.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back-Fusion
After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or

without neurologic compromise after 6 months of compliance with recommended [conservative therapy](#).

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 & 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

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)**