SENT VIA EMAIL OR FAX ON
Feb/16/2009

IRO Express Inc.

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DATE OF REVIEW:
Feb/11/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Posteriolateral and interbody fusions, L3/4 with cages, plates, screws osteofill, use of fluoroscopy, allograft, and autograft, standard brace with 3 day inpatient LOS

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:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
RME, Dr., 11/28/06
EMG/NCS, 06/12/07
MRI lumbar, 01/02/08
Office note, Dr., 03/12/08
H&P, Dr. 04/01/08
DDE, Dr., 06/12/08
MRI right ankle, 06/24/08
Office notes, Dr., 08/25/08, 11/10/08
Office notes, Dr, 09/08/08, 10/06/08, 12/10/08
CT discogram, 10/13/08
Office note, Dr., 10/21/08
Impairment Review, Dr., 11/04/08
Review, 12/12/08
Appeal, 12/22/08
IRO summary, 01/29/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year who reported an injury on xx/xx/xx when his right foot was caught between a pallet jack and a forklift resulting in a right foot crush injury and low back injury. Initial treatment records were not provided for review. The claimant treated concurrently for a right calcaneus fracture, right talar fracture, anterior tibiofibular ligament injury, possible reflex sympathetic dystrophy and right knee internal derangement. The claimant is a smoker. This review will focus on the lumbar spine.

The first record provided was dated xx/xx/xx by Dr., chiropractor, with findings of lumbar tenderness; 3+ symmetrical reflexes; normal strength; and intact sensation. The claimant was noted to be treating with Daypro, Lortab, Zanaflex, Lyrica, Clonazepam, activity modification and chiropractic modalities. Recommendation was made for aggressive physical therapy. Electrodiagnostic study of the right lower extremity completed on xx/xx/xx was essentially normal without evidence of neuropathy or lumbar radiculopathy. Lumbar MRI evaluation performed on 01/02/08 noted an L3-4 two-millimeter disc protrusion with annular tear, mild degenerative changes and no significant stenosis or impingement. The claimant continued to report increasing low back pain to the right foot and spasms. An epidural steroid injection was recommended and denied. Physical examination on 04/01/08 demonstrated an antalgic gait and decreased sensation at the lateral right foot. The claimant was authorized for ten work hardening session but was only able to complete about a week due to pain and no significant improvement. Reference was made to pending right ankle surgery.

A designated doctor evaluation by Dr., podiatrist, on 06/12/08 indicated the claimant could not meet the job requirements of medium demand and was considered to be at maximum medical improvement with a nine percent impairment rating. The claimant continued to undergo chiropractic management for the right foot and low back. On 08/25/08 examination noted right ankle strength at 4/5. On 09/08/08 Dr. indicated the claimant had complaints of bilateral leg numbness and a feeling like her legs would give out. The claimant was given insoles and medications were continued. On 10/06/08 the claimant was referred back to Dr. for surgical consideration. CT/discogram evaluation conducted on 10/13/08 noted an L3-4 grade 4 posterior radial fissure with concordant 10/10 pain and L4-5 disconcordant sensation of numbness with normal nuclear morphology. Dr. diagnosed L3-4 discogenic pain persistent since 2006 and nonresponsive to conservative management. Recommendation was made for L3-4 posterior instrumented fusion. On 11/04/08, an impairment rating evaluation by Dr. noted a history of bowel problems without details provided and weight gain, as well as reference to a psychiatric evaluation that confirmed the claimant was a candidate for pain management. Physical examination on 11/04/08 demonstrated a slow unsteady gait; poor heel and toe walking; lumbar spasm and tenderness; limited lumbar motion; bilateral lower extremity weakness at 3/5 with great toe extension at zero; negative Waddell; and intact sensation and reflexes. The claimant was again noted to be at maximum medical improvement with a five percent impairment rating. The claimant continued to be symptomatic. Dr. indicated the diagnostic injection was denied; the claimant had increasing pain; and the claimant was unable to work. Recommendation for L3-4 fusion was made again.

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

The requested L3-L4 interbody fusion with grafting, bracing, and three-day length of stay is not medically necessary based on review of this medical record.

This claimant was injured in xxxx and has continued to have back pain. On 01/02/08 he underwent an MRI of the lumbar spine documenting an L3-L4 tiny disc bulge with no evidence of disc herniation, stenosis or nerve root impingement. While he has continued to have ongoing back complaints and underwent a 10/13/08 CT discogram that documented pain at the L3-L4 level, there is no documented evidence of structural instability, large disc herniation, tumor, or other abnormality.

The Official Disability Guidelines document the use of lumbar fusion in patients who have

tumor, infection, structural instability or revision disc herniation surgery. In this case, those do not appear to be evident and therefore the requested surgical intervention is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA 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

[X] 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

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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