

SENT VIA EMAIL OR FAX ON  
Oct/20/2009

## Applied Resolutions LLC

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Oct/20/2009

**IRO CASE #:**

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

Lumbar Laminectomy Microdiscectomy L1-2

**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**

OD Guidelines

MRI left knee, 01/25/08

MRI thoracic spine, 01/25/08

MRI thoracic spine, 01/25/08

Office note, Dr., 04/24/08, 01/21/09, 02/18/09

Lumbar spine MRI, 05/22/08

MRI thoracic spine, 05/27/08

Lumbar spine X-rays, 08/25/08

FCE, 01/05/09

Office note, Dr. 01/29/09

Office note, Dr., 03/04/09

Letter, Dr., 03/25/09

Peer review, Dr., 04/16/09

Office note, Dr., 06/15/09 thru 9/1/09

Peer review, Dr., 09/01/09

Peer review, Dr. , 09/02/09  
Record review, Dr., 09/09/09  
Peer review, Dr., 09/15/09  
OP Report 6/17/08

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is a xx-year-old male with complaints of low back and mid back pain. The MRI of the thoracic spine from 01/25/08 showed scoliosis of the thoracic spine. There was anterior vertebral osteochondrosis of T5-6, T6-7 and to a minor extent T7-T8. There was almost complete collapse of the vertebral collapse of the vertebral interspace at C5-6 and T6-7, which also showed Modic inflammatory changes of endplates. Incidental findings of a rather large bulge in the posterior aspect of L1-2 was reported. A second MRI of the thoracic spine from 01/25/08 showed a compression fracture's of three thoracic vertebrae, acute/subacute, with evidence of only of minimal compression in the upper plates. Mild degenerative changes in the lower part of the images, compatible with a mild bulge of either the lower thoracic or upper lumbar disc not compressing the spinal cord was reported. The lumbar spine MRI showed at L1-2 a disc signal intensity and the disc height were mildly diminished with mild broad based bulging that produces mild compression of the thecal sac. There was mild thickening of the yellow ligament and mild narrowing of the neural foramina and lateral canals bilaterally. At L4-5, the disc signal intensity was within normal limits with preservation of the disc height with minimal bulging, no spinal stenosis and herniation or neural foramina encroachment and facets were normal. The MRI of the thoracic spine showed evidence of marrow changes in the anterior inferior aspect of T8 and T9 chronic in type. No evidence of a fracture or a herniation was seen. The lumbar spine x-rays showed mild degenerative changes. Dr. followed the patient in early 2009 for pain management. On 03/04/09, Dr. noted that the claimant had undergone epidural steroid injection on 01/17/09 without benefit. Dr. evaluated the claimant on 06/15/09 for severe back pain at the thoracolumbar junction with radiation into the buttocks and thighs. Examination revealed 3 beats of clonus on the right, 2 beats of clonus on the left and positive femoral stretch on the left. There were paresthesias along the left L2. Dr. noted that the x-rays of the lumbar spine showed no fracture/subluxation. The diagnosis was protrusion at L1-2 with some evidence of long tract signs. Dr. recommended repeat lumbar epidural steroid injection. On 08/17/09, Dr. evaluated the claimant. The claimant reported the lumbar epidural steroid injection from 07/24/09 was minimally helpful. The examination revealed back tenderness with painful lumbar range of motion, diminished sensation along left L2 distribution, positive femoral stretch test and slightly diminished left patella reflex. Dr. has recommended decompression at L1-2.

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

The requested lumbar microdiscectomy at L1-2 cannot be justified based on the information provided.

The MRI of 05/22/08 showed rather mild degenerative changes at the L1-2 level. The claimant did not have significant neural foraminal compromise. The claimant did not have a clear consistent dermatomal pattern to complaints. The claimant had no help from an epidural steroid injection of 01/17/09. If the claimant had true radiculopathy, a transient favorable response is often found. There are no electrodiagnostic studies to support a diagnosis of radiculopathy. It is not clear that the claimant's minimal pathology noted by MRI is contributing to the claimant's symptoms.

For these reasons, the requested surgery cannot be justified based on the information provided.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back, laminectomy and discectomy

#### **- Lumbar Laminectomy/discectomy**

ODG Indications for Surgery™ -- Discectomy/laminectomy --Radiculopathy,

weakness/atrophy, EMG optional, Imaging for correlation with radicular findings. Activity modification of 2 months and at least one of the following; Nsaids, analgesic, muscle relaxants, ESI. Must have **one** of the following PT, chiro. Psychological screening, back school. Diagnostic imaging modalities, requiring ONE of the following: MR imaging, CT scanning, Myelography CT myelography & X-Ray

**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

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)