

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 07/30/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:

SSEP, 05/28/10

2 day inpatient hospital stay, 05/28/10

Flourosocopy, 05/28/10

Removal lumbar instrumentation L4-5, subtotal laminectomy L2, Laminectomy at L3, 05/28/10

Subtotal laminectomy at L2 Laminectomy at L3, 05/28/10

Laminectomy at L3 and L4, 05/28/10

Discectomy L2-3 and L3-4, 05/28/10

Interbody fusion at L3-4, 05/28/10

Reinstrumentation L4, 05/28/10

Pedicle screws fixation L2 and L3, 05/28/10

PSF L2-4, 05/28/10

Right ICBG, cages, 05/28/10

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

Texas Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 05/23/07 - MRI Lumbar Spine
2. 01/29/08 - Clinical Note -, MD
3. 05/20/08 - Clinical Note -, MD
4. 07/02/08 - Clinical Note -, MD
5. 07/07/08 - Clinical Note -, MD
6. 10/07/08 - Clinical Note -, MD
7. 12/05/08 - Letter -, MD
8. 01/21/09 - Clinical Note -, MD

9. 04/09/09 - CT Cervical Spine
10. 05/21/09 - MRI Cervical Spine
11. 06/19/09 - Clinical Note -, MD
12. 09/01/09 - Designated Doctor Evaluation
13. 11/10/09 - Clinical Note -, MD
14. 03/29/10 - Mental Health Evaluation - M.Ed, LPC
15. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx when she fell forward onto her knees while carrying two heavy boxes.

The clinical notes begin with a MRI of the lumbar spine performed 05/23/07 that demonstrated loss of interspace between L4 and L5. There was a circumferential disc herniation at L2-L3 with mild to moderate stenosis of the right intraforaminal canal and a hyperintensity focus that represents tears within the annular fibers. At L3-L4, there was a disc herniation with downward compression of the thecal sac and a mild to moderate stenosis of the central neural canal in the anteroposterior diameter. Ligamentum flavum thickness caused narrowing of the transverse diameter of the central neural canal.

The employee saw Dr. on 05/20/08 with complaints of low back and leg pain. The employee stated the pain was predominately right sided and radiates from the low back into the hip and thigh. There was associated numbness and tingling. The employee rated the pain at 8 out of 10 on the visual analog scale. The pain worsened with twisting, lying down, sitting, weather, walking, sleeping, running, driving, and bending. The pain was relieved by massage, cold, heat, muscle relaxants, anti-inflammatory medication, muscle strengthening, pain medications, electrical stimulation and chiropractic care. Current medications included Robaxin, Vicodin, Skelaxin, Wellbutrin, Effexor, Trazodone, Celebrex, and Lyrica. The neurological examination revealed decreased sensation to the posterior part of the leg. There was paraspinal muscle spasm of the low back. There were decreased reflexes in the ankles and knees. Prior radiographs demonstrated instrumentation at L4-L5 with calcified bone mass bilaterally. Prior electrodiagnostic studies revealed right L2 to L4 acute radiculopathy and right L4 to L5 chronic radiculopathy. This clinical note appeared incomplete.

A letter by Dr. dated 07/02/08 stated the employee returned for follow-up indicating her symptoms were becoming worse with radicular pain to the right lower extremity. The letter stated a MRI dated 06/12/08 demonstrated progression of spondylosis and mobic changes of the endplate of the L2-L3 disc. There was retrolisthesis present and a herniated disc with collapse at L3-L4. There was moderate to severe stenosis, especially on the right side. The employee was recommended for removal of spinal instrumentation at L4-L5, re-instrumentation of the L4 pedicle with new screws, discectomies at L3-L4 and L4-

:5, and interbody fusion at L3-L4. The employee would also need vocational retraining after the surgery.

The employee returned to Dr. on 07/07/08. The physical examination was unchanged. The employee was recommended for L2-L3 and L3-L4 reconstruction with interbody fusion and posterolateral arthrodesis with instrumentation.

A letter by Dr. dated 12/05/08 discussed the employee's previous treatment. Radiographs performed 05/15/07 demonstrated a solid fusion from L4 to sacrum. There were early degenerative changes of the segments at L2-L3 and L3-L4. The employee was assessed with sprained back and was treated with anti-inflammatories. The employee underwent a pain management program that included injections, but the employee stated this did not improve her symptomatology. A lumbar myelogram and CT performed 01/03/08 demonstrated postsurgical changes from L4 to sacrum and retrolisthesis of L2-L3 with facet hypertrophy in L2-L3 and L3-L4 segments. The letter stated the employee had a severe spinal condition that resulted in severe pain and disability. The employee also suffered from severe depression due to the pain and frustrations of dealing with the insurance company. The employee was recommended for a psychiatric or psychological evaluation.

A CT of the cervical spine performed 04/10/09 demonstrated no evidence of acute osseous or soft tissue abnormality. There was multilevel degenerative disc disease with associated degenerative changes.

An MRI of the cervical spine performed 05/21/09 demonstrated straightening of the cervical lordotic curve due to muscle spasm. There was a broad-based posterior protrusion and subligamentous disc herniation at C5-C6 in the central and right lateral aspect measuring 2.8 mm in diameter causing moderate right foraminal stenosis.

A Designated Doctor Evaluation was performed on 09/01/09. The employee complained of low back pain with associated soreness, stiffness, and numbness. The symptoms were constant and caused serious diminishment of her ability to carry out activities of daily living. The employee reported an estimated 30% improvement since the initial injury. The prior treatment included prescription medications, physical therapy, and epidural steroid injection. The physical examination revealed muscle tightness, spasm and discomfort to palpation of the paralumbar muscles. There was also pain to palpation of the right sacroiliac joint. There was no palpatory evidence of joint fixations, articular or segmental dysfunction in the lumbosacral pelvic regions. The employee was assessed with lumbago, radiculopathy, lumbar sprain/strain, and right SI joint dysfunction. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

A mental health evaluation was performed on 03/29/10. Current medications included Norflex, Mobic 7.5 mg, Lorcet 650 mg, Neurontin 800 mg, Meloxicam, Amitriptyline, and Trazodone. The employee's BDI score was 19, indicating mild depression. The BAI score is 13, indicating mild anxiety. The note stated there were no psychological issues that would prevent the employee from benefiting from the recommended surgery.

The request for removal of lumbar instrumentation L4-5, subtotal laminectomy L2, Laminectomy at L3 and L4, discectomy L2-L3 and L3-L4, interbody fusion at L3-L4, re-instrumentation at L4, pedicle screw fixation L2 and L3, PSF L2-L4, right ICBG, cages, Fluoroscopy, SSEP monitoring, and two day inpatient hospital stay was denied by utilization review on 06/07/10 due to no recent documentation identifying subjective/objective complaints, recent imaging findings, or diagnosis/condition demonstrating a reason, such as instability, for which fusion is indicated.

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

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Flouroscopy, 05/28/10

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is not supported by the clinical documentation. As the prior denial indicates, there is no recent evaluation of the employee identifying any complaints or physical examinations identifying objective evidence of functional deficits that would reasonably require the requested procedures. Although the employee has been cleared psychologically for the procedure, an updated and in-depth neurological examination of the employee documenting objective evidence to support the requested procedures would be appropriate to establish medical necessity.

Therefore, the request for:

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would not be deemed medically necessary.

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

1. ***Official Disability Guidelines***, Online Version, Low Back Chapter