

SENT VIA EMAIL OR FAX ON  
Nov/29/2010

## Pure Resolutions Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Nov/29/2010

**IRO CASE #:**

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

Lumbar Laminectomy/Discectomy @L5/S1; Additional Level; Microdissection Technique; Lumbar Spine Arthrodesis Lateral @L5/S1; Intervertebral Biomechanical Device; Lumbar Autograft; Posterior Non-Segmental Instrumentation; Anterior Lumbar Arthrodesis @L5/S1; Reduction of Subluxation @L5/S1; Inpatient Hospital Stay X 2 days

**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

X-rays pelvis, 12/05/08

MRI Lumbar Spine, 01/21/09

Office note, Dr. 03/20/09

Peer Review, Dr. 03/23/09

MRI left foot, 03/25/09

EMG/NCV studies, 09/24/09

Office visits, Dr. 02/05/10, 05/13/10, 05/28/10, 06/17/10, 07/09/10, 07/29/10, 08/12/10, 09/02/10, 10/15/10, 10/29/10

509 pages from Group 12/5/08 thru 11/11/10

Office visits, Dr. 05/26/10, 07/28/10, 08/09/10

Office visits, Dr. 06/10/10, 06/17/10, 06/29/10,

Office visits, Dr., 06/16/10, 08/16/10  
Office visits, Dr. 06/16/10, 06/30/10, 07/15/10,  
Mental Health Evaluation, 09/02/10  
MRI Scan Review, Dr. 09/13/10  
Office Visit, Dr. 09/14/10  
Pre-surgery Mental Health Screening, 09/21/10  
Independent review organization summary, 11/11/10

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

The claimant is a female who was struck by a vehicle while walking into a facility on xx/xx/xx. She sustained an injury to her hips/buttocks. Her history is also significant for multiple sclerosis (MS). X-rays of the pelvis on 12/05/08 showed mild osteoarthritis. A lumbar MRI on 01/21/09 revealed a broad based disc bulge and a central disc protrusion at L5-S1 without high grade central canal narrowing and moderate-to-severe bilateral neural foraminal narrowing with facet degenerative changes. No definite annular tear was appreciated on this study. There was no abnormal enhancement of the conus medullaris appreciated.

She underwent a right knee arthroscopy in 02/09.

Dr. performed a peer review on 03/23/09 and opined that there was no acute structural change to the lumbar or cervical spines or left shoulder as related to the work event of xx/xx/xx and the claimant should be having improvement in those body parts.

EMG/NCV studies on 09/24/09 showed normal peroneal and tibial motor nerves bilaterally on NCV studies of the feet. The needle EMG showed no denervation.

Dr. saw the claimant on 02/05/10 for bilateral knee pain, bilateral hip pain and low back pain. She brought in a report of a previous MRI and a note from her neurologist, which stated that her current complaints were not related to MS. The claimant reported moderate to severe pain in both hip areas with difficulty walking and cramping in the bilateral lower extremities and ongoing bilateral knee pain. Examination of the lumbar spine and bilateral lower extremities showed tenderness all along the bilateral hip and lumbar area. Straight leg raise caused discomfort in lumbar spine area. Multiple trauma, history of MS, right knee pain status post two right knee surgeries (it is unclear when the second surgery was done), left knee pain with meniscal injury, lumbosacral radiculitis and lumbar nerve root irritation were diagnosed. She was referred to an orthopedic surgeon for the left knee and advised to continue therapy. Labs, off work and a Flector patch were recommended.

The claimant was re-evaluated on 05/13/10 and was noted to have recently underwent left knee arthroscopic surgery and was doing rehabilitation. The left pain was partially improved. She reported pain in multiple joints including increased right knee pain due to overuse and low back pain. The lumbar injections were on hold due to the knee surgery and until she was released from such. Her medications included: Celebrex, Amrix, Carbatrol and Lortab. The examination showed tenderness of the lumbar spine extending to the bilateral hip area, restricted motion and positive straight leg raise on the left with weakness in the bilateral lower extremities. Once released for the knee she was to have a lumbar injection.

Dr., pain management physician saw the claimant on 05/26/10 for moderate to severe low back pain radiating down the left lower extremity to the foot and on the right side to the thigh level. She was noted to have an L5-S1 disc protrusion/extrusion and L4 and L5 disc bulge. She was noted to have had 5-6 weeks of therapy for her back with minimal relief and also medication management including pain medications and muscle relaxants. A left L5 and S1 transforaminal epidural steroid injection was recommended. The 05/28/10 examination noted restricted lumbar motion, positive straight leg raises bilaterally and decreased strength on the left. On 06/10/10 a left L5 transforaminal epidural steroid injection was administered.

Dr. saw the claimant on 06/16/10 at which time the left knee was better, but she had pain in the lateral hamstring when trying to flex or contract the hamstrings and it radiated up the leg.

She was having more problems with her back. She stated she was worse since the injection. She sat with a list to the right and had a positive straight leg raise on the left. A repeat MRI was recommended, but he stated it looked as though surgery for the low back would be needed. Hydrocodone was refilled, Celebrex was increased and she was to continue Amrix.

Dr. saw the claimant on 06/17/10 and noted that the 06/10 injection improved her radicular symptoms but it increased the mid back pain. She was also being seen by Dr. for her left knee pain who felt it was from her low back. On examination paraspinal muscle spasms were noted, straight leg raise was positive bilaterally and there was decreased strength in the bilateral lower extremities.

Dr. saw the claimant on 06/17/10 stating the left lower extremity pain had resolved at least 70 percent and was no longer having any numbness or tingling in the leg, but had left sided low back spasms and difficulty sitting for long periods. Her MS was noted to have been in remission for the last 2 years. The examination showed palpation of the left iliolumbar musculature was very tender with trigger points. In sitting she was unable to tolerate straight leg raise examination on the left or right as it increased her left sided muscle spasms. Motor testing of the greater toe extension and flexion were 5/5 and showed no deficits, however ankle flexion and extension on the left aggravated her left iliolumbar musculature. There were deficits to pinwheel exam on the left calf L5-S1 dermatomes as compared to the right. Reflex testing was symmetric in both of her Achilles tendon areas. She was noted to have had an excellent 70 percent overall decrease in radiculopathic left pain symptoms since the injection. She was noted to have a disc protrusion at L5-S1 as her pain generator. He felt however she was having post inflammatory injection left sided myofascial pain syndromes. Prednisone was given. Dr. re-evaluated the claimant on 06/29/10 and noted the Prednisone had improved her muscle spasms. Overall her low back pain was 5 and had excellent relief of left lower extremity radicular symptoms, but had begun to have mild return into left buttock and just above the left knee without numbness or pain into the left foot. Her MRI of 2009 was noted to show an L5-S1 disc protrusion. The claimant reported recent weakness in the right knee, which caused her to fall. The examination showed palpation of the left iliolumbar musculature was very tender. In sitting position straight leg raise on the "right" was negative, but on the "right" was positive for nerve tension pain at about 60 on the left and down the posterior leg. Motor and reflex testing of the lower extremities were symmetric without deficits. There were neurosensory deficits on the left L5-S1 dermatomes to pinwheel exam on the left compared to the right. Provocative testing of left SI joint was positive for Patrick's and shear compression testing. The claimant wanted to avoid surgery at all costs. A second L5 and left SI transforaminal injection was recommended.

Dr. DC saw the claimant on 06/30/10 and indicated that she had a right lateral list and was mildly forward flexing away from her left sciatic nerve distribution. She said she was doing extremely well post the injection, but began with moderate discomfort sitting on the left side. He indicated that she had 9 sessions of therapy for the lumbar spine, but that the lumbar spine discogenic pathology had not been evaluated or treated to any substantial magnitude and has been through no care almost whatsoever until the recent injection since the injury.

On 07/09/10 Dr. saw the claimant and stated that in the past 2 weeks she had noticed progressive weakness in the right lower extremity and the knee buckled up about a week prior and she fell hitting her elbow to the walls. She felt she did not have too much sensation in the right lower extremity and had intermittent left lower extremity paresthesias and intermittent left knee pain. Examination showed restricted lumbar motion, positive straight leg raise bilaterally, loss of sensation of the right lower extremity with hard to elicit reflex in the right ankle area; it was 0-1+ with reinforcement and was 1+ in the left ankle and bilateral knees. Norco, Lidoderm patch, Celebrex, off work and a second injection were advised.

Dr. re-evaluated the claimant on 07/15/10 and noted continued right lateral list that slowly resolved. On 07/28/10 a left L5 transforaminal epidural steroid injection was given. The claimant saw Dr. on 07/29/10 and reported increased mid back pain and difficulty sitting down and increased right lower extremity radicular symptoms, but overall her pain had improved, especially the left lower extremity weakness and paresthesia. Lumbar motion was restricted,

straight leg raise elicited pain on the right side with loss of sensation in the right lower extremity and absent reflex in the right ankle area. Post injection therapy was advised.

Dr. saw the claimant on 08/09/10 and noted that she had good, but only very temporary relief for about 5 days post injection. Her pain returned, but was not quite as severe as prior to the injections, but was 4-5 with left lower extremity radiation to the knee and on the right down to the buttocks area. The examination showed bilateral paraspinous muscle spasm greater on the left, positive straight leg raise on the left at 40 degrees with numbness and tingling in the left calf, normal right knee and ankle reflexes and 1+ left knee and ankle reflexes. There was decreased sensation to neurosensory pinwheel testing in the left L5-S1 dermatomes compared to right. Dorsiflexion of the right great toe was 5/5 and left great toe 4/5. Dr. stated the claimant had failed interventional pain management and that she would require surgical consultation. Dr. saw the claimant again on 08/12/10 stating the 2nd injection did not help. She reported low back pain traveling to the bilateral posterior thighs, bilateral hip pain and bilateral knee pain. There was tenderness in the midline area, paraspinal muscle spasms, positive bilateral straight leg raise and pain in the bilateral greater trochanteric bursa with painful motion of the hips and generalized weakness in the bilateral lower extremities with 1+ reflexes in the knee and ankle area.

Dr. saw the claimant on 08/16/10 for more pain in the back with left lower extremity radiation. Straight leg raise was positive at 40 degrees on the right and 30 degrees on the left. She was able to heel/toe walk, had intact reflexes and decreased sensation on the left in the L5 dermatome and on the right in the S1 dermatome. Straight leg raise was positive sitting and supine. The 09/02/10 examination showed tenderness in the midline area, painful SI joints, pain in the greater trochanteric area of both hips, restricted and painful motion in the lumbar spine, positive straight leg raise on the left and generalized weakness in the bilateral lower extremities. Reflexes were active and symmetrical.

A mental health evaluation on 09/02/10 noted her primary physician had noted concerns of depression and anxiety. Psychological testing was advised.

On 09/13/10 Dr. reviewed the MRI, date not indicated and noted it to show reveals L4-5 bulging disc versus grade I herniation. The L5-S1 contained disc herniation rated as stage II with annular herniation, nuclear protrusion, disc desiccation consistent with T2 weighted image changes and spinal stenosis. Dr. evaluated the claimant on 09/14/10 for back pain radiating into the legs greater on the right that day, but was sometimes worse on the left. She was noted to have failed conservative care over nearly a 2-year period. He indicated that Dr. recommended surgery. She was noted to be a non-smoker. Lumbar x-rays with flexion/extension views showed L5-S1 extension angle measures 25 at end-plates, forward flexion 6 for a total change of 19 degrees with facet subluxation, foraminal stenosis and collapse of the functional spinal unit down to 4 millimeters with normal being 10-15 millimeters. The examination showed positive spring test L5-S1, positive extensor lag, positive sciatic notch tenderness bilaterally, but worse on the right, decreased ankle jerk on the right, absent posterior tibial tendon jerks bilaterally, paresthesias in L5 and S1 nerve root distribution on the right, S1 nerve root distribution on the left and no gross motor deficits, positive extensor lag. L5-S1 herniated nucleus pulposus with right greater than left radiculopathy with clinical instability and failure of conservative care were diagnosed. Decompressive lumbar laminectomy, discectomy, and arthrodesis with internal fixation, EMG/NCV has already been done and psychological clearance was recommended.

Pre-surgery mental health screening on 09/21/10 noted her prognosis for surgery good, but recommended 6 more sessions of cognitive behavioral therapy. Dr. saw the claimant on 10/15/10 at which time it was noted that on 10/14/10 she was trying to shave her leg in a bent position and the right knee locked and she fell hitting the right knee and right side of her head on the bathtub. The examination showed generalized weakness in the bilateral lower extremities and active and symmetrical reflexes. A CT of the head was recommended. At the 10/29/10 follow-up there was lumbar restricted motion and pain in the bilateral hips. She wanted to proceed with the lumbar fusion recommended by Dr.. Dr. was a little hesitant about the approach due to her MS and wanted a recommendation by her neurologist.

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

The proposed L5-S1 decompression and fusion cannot be recommended as medically necessary.

If one looks towards the Official Disability Guidelines indications for spinal fusion, x-rays should demonstrate instability. In this case, the claimant has a herniated L5-S1 disc. There is no evidence of instability or spondylolisthesis. Therefore, based upon the Official Disability Guidelines, L5-S1 decompression and fusion surgery is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 15<sup>th</sup> edition, 2010 Updates – (Low Back Chapter – discectomy, fusion)

**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)