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Amended Notice of Independent Review Decision

DATE OF REVIEW: February 3, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient; 1night; lumbar laminectomy with fusion and instrumentation L4-5, L5-S1; and thoracic-lumbar-sacral orthosis (TSLO) back brace at Shannon Medical Center.

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

AMERICAN BOARD OF NEUROLOGICAL SURGERY

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008

- Management Fund, 07/14/08, 02/23/09, 10/12/09, 11/30/09, 12/03/09, 12/21/09, 12/29/09, 01/12/10
- Company Request for IRO, 01/11/10
- Request for a Review by an Independent Review Organization, 01/11/10
- M.D., 11/30/09, 12/21/09, 10/12/09, 10/08/09, 11/23/09, 12/17/09
- Memorial Hospital, 10/27/09
- 02/20/09
- Neurosurgical Associates, L.L.P., 09/15/08, 02/20/09
- M.D., 11/25/08, 01/05/09, 01/23/09
- MRI Lubbock, 07/18/08
- Health System, 09/15/08
- M.D., P.A., 09/26/08

Medical records from the Requestor/Provider include:

- Medical Group, 07/14/08, 07/22/08, 09/29/08, 05/21/09, 06/03/09, 06/18/09, 08/05/09
- Associates, L.L.P., 09/15/08
- Health Plus, 10/20/08, 05/21/09, 06/03/09, 06/18/09, 08/05/09,
- M.D., 05/14/09
- MRI Lubbock, 07/18/08
- D.C., 08/14/09
- M.D., P.A., 09/09/09, 09/14/09, 09/18/09
- Accident and Injury Rehab, 10/05/09, 10/07/09
- M.D., 10/08/09, 11/23/09, 12/17/09

PATIENT CLINICAL HISTORY:

At your request, I have reviewed the available medical records of Mr..

As you know, this is a male who reports an on-the-job injury on xx/xx/xx.

The records begin with an evaluation by M.D., on July 14, 2008. The patient complained of low back pain and right lower extremity pain. The patient had been shoveling at work during the day, and at the end of the day, he developed low back pain. Over a three-day weekend, he developed right lower extremity pain. On examination, he had full strength and decreased sensation along the right shin. He had normal reflexes. According to Dr. x-rays revealed an L5-S1 retrolisthesis.

On July 18, 2008, the patient underwent a lumbar MRI which revealed a large and central disc herniation at L5-S1 with moderate-to-severe central canal stenosis and mild bilateral foraminal stenosis. There was a small disc herniation at L4-5 with mild canal and mild bilateral foraminal stenosis.

Dr. saw the patient on July 22, 2008, with complaints of back and right lower extremity pain.

The patient was then seen by M.D., on September 15, 2008. The patient had low back pain. His right lower extremity complaints had resolved. The patient had full strength on examination, along with normal reflexes and a negative straight leg raise bilaterally. Flexion and extension x-rays revealed no subluxation.

The patient underwent electrical studies (EMG/NCV) of his lower extremities on September 26, 2008. These studies were normal.

On September 29, 2008, the patient had no complaints of bowel or bladder problems and no complaints of lower extremity weakness or numbness. On examination, he had full strength, sensation, and reflexes.

The patient was seen by M.D., on May 14, 2009. He had complaints of low back pain. Injections had not been helpful.

Dr. saw the patient again on May 21, 2009. She noted the patient had low back pain without radiation to the legs. On examination, the patient had full muscle strength, normal sensation, and normal reflexes.

Dr. saw the patient again on June 3, 2009. The patient had complaints of low back pain without lower extremity weakness or numbness. He had no bowel or bladder complaints. On examination, he had normal sensation and muscle strength and normal reflexes.

The patient again was seen by Dr. on June 18, 2009. There were no complaints of leg pain. The patient had low back pain, but no leg weakness or numbness. He had full strength on examination along with normal sensation and reflexes.

On August 5, 2009, Dr. noted complaints of low back pain and right hip pain along with normal muscle strength, normal sensation, and normal reflexes.

On September 9, 2009, M.D., noted the patient had low back pain without radiation of the pain to his legs. He denied lower extremity numbness. Dr. recommended an epidural steroid injection.

On September 14, 2009, Dr. noted complaints of low back pain without radiation.

On September 18, 2009, Dr. indicated the patient had 4/5 strength in the right quadriceps and the right hip adductors.

In October of 2009, the patient had physical therapy.

M.D., saw the patient on October 8, 2009. According to Dr., the patient had complaints of low back pain and “discomfort in the legs, particularly on the right, with numbness and dysesthesias.” Dr. noted the patient tried physical therapy, chiropractic treatment, and epidural injection without benefit. Dr. noted the patient had mild weakness of plantar and dorsiflexion. A patient questionnaire was also provided in the records. This questionnaire that was reportedly filled out by the patient noted complaints of low back pain, which was circled. The references to leg pain were denied by the patient, according to this patient questionnaire.

On October 27, 2008, the patient underwent a lumbar myelogram. This revealed a mild-to-moderate extradural defect at L4-5 with no nerve root amputation. There was no reference to any abnormality at L5-S1. According to the report of the CT scan performed after the myelogram, there was a disc bulge at L4-5 with mild-to-moderate canal stenosis and mild bilateral foraminal narrowing. At L5-S1, there was a 3 mm subluxation of L5 on S1 without nerve root compression.

On November 23, 2009, Dr. reported complaints of low back pain and bilateral radiating hip and leg pain. Although, again it appears there is a patient questionnaire at this same time in which the patient denied leg pain.

On December 17, 2009, Dr. recommended surgery and fusions at L4-5 and L5-S1.

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

The request for a lumbar laminectomy with fusion at L4-5 and L5-S1 should be denied. This surgery is not indicated. Based on the ODG, surgery is indicated if the patient has radicular pain and has corresponding findings on examination, and the history and the examination are correlated with the MRI. That is not the case for the patient. The patient’s history, examination, and MRI do not correlate. The patient does not have leg pain. Although Dr. indicates he has leg pain, the record repeatedly indicates that the patient has low back pain without leg pain. Repeatedly, there is a mention by Dr. and Dr. that the patient has back pain without radiation. These records are just prior to Dr. visits. Therefore, there is certainly contradiction regarding the presence of leg pain. The records also support a normal neurological examination repeatedly performed by Dr. and the months prior to Dr. visit. Dr. then notes mild weakness of plantar and dorsiflexion. This is not quantified. Dr. notes weakness of the right quadriceps and right hip adductors. There is not a consistent and clear evidence of weakness, and it is not clear if there is any weakness and if so, which nerve root distribution. In addition, the latest radiographic study which is the myelogram and CT scan performed on October 27, 2009, does not demonstrate any nerve root compression. There is a defect at L4-5, i.e. disc herniation, which causes mild-to-moderate canal stenosis and mild foraminal stenosis. There is no evidence of nerve root compression. If the patient was symptomatic from canal stenosis,

he should have consistent complaints of bilateral lower extremity pain, particularly with ambulation. At L5-S1, there is a 3 mm subluxation, but no evidence of nerve root compression. There is no evidence in the records that there is instability at this level, i.e. no evidence that there is movement beyond the 3 mm. At 3 mm, there is no documented nerve root compression. Therefore, the patient is not a surgical candidate. He does not have evidence of nerve root compression, and his history, examination and radiographic findings do not correlate, and therefore, surgery is not warranted. Based on the records, the patient has complaints of low back pain which is consistently documented. Based on the ODG, a lumbar fusion may be recommended as the treatment for carefully selected patients with disabling low back pain. This recommendation was based on one study that contained numerous flaws, including a lack of standardization of conservative care in the control group. In addition, there remains no direction regarding how to define “carefully selected patient.” Therefore, surgery is not indicated because there is a lack of clearly documented clinical trials and support for surgery for low back pain.

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)**