

SENT VIA EMAIL OR FAX ON  
Jun/05/2010

## True Decisions Inc.

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

**DATE OF REVIEW:**

Jun/05/2010

**IRO CASE #:**

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

Lumbar Surgery to include exam, lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, bone growth stimulator implant at L4/5/S1, discectomy at L3/4

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

Board Certified Neurosurgeon with additional training in pediatric neurosurgery

**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

Denial Letters 5/14/10 and 4/30/10

Dr. 6/30/09 thru 4/13/10

MRI 7/17/09

Pre-Surgical Screening 9/2/09

Lumbar Spine 4/1/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a female with a date of injury xx/xx/xxxx at work. She complains of low back and bilateral leg pain. Her neurological examination reveals a decreased knee jerk and ankle jerk on the right. There is mild weakness of gastoc-soleus, extensor hallicus longus, and tibialis anterior on the right. An MRI of the lumbar spine 07/17/2009 reveals at L3-L4 mild

disc dessication with 2mm retrolisthesis with 2mm disc bulge and questionable right lateral annular tear. At L4-L5: 2-3mm of retrolisthesis, 2mm disc bulge, and no significant central or foraminal stenosis. At L5-S1 there is moderate disc dessication with loss of height, 3mm of retrolisthesis, 3mm AP dimension central to left paracentral disc herniation. There is posterior displacement of the left S1 nerve root in the lateral recess. There is no significant foraminal stenosis. Plain films of the lumbar spine 04/01/2010 reveal 3mm of retrolisthesis at L2-L3 and L4-L5 in extension and neutral alignment in flexion. At L3-L4 there is 3.5 mm of retrolisthesis in extension and neutral alignment in flexion. At L5-S1 there is 2mm of anterolisthesis in flexion and 2mm of retrolisthesis in extension. A pre-surgical psychological evaluation 02/07/2009 revealed a good prognosis for the procedure. The provider is requesting a lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation, bone growth stimulator implant at L4-L5, L5-S1, with discectomy at L3-L4.

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

Based on the submitted documentation, the surgery is not medically necessary. The flexion and extension films show movement on flexion and extension at L2-L3, L3-L4, L4-L5, L5-S1. The MRI shows a retrolisthesis at L3-L4. The provider wished to decompress L3-L4, but it is not clear that there is anything pathology to decompress. Further insight is needed as to the rationale behind the fusion construct. Based on the radiology reports, L5-S1 shows disc dessication and loss of disc height as well as nerve root compression. The severity of the findings at the other levels is not clear. Therefore, the request, as a whole, is not medically necessary.

#### **References/Guidelines**

2010 *Official Disability Guidelines*, 15th edition

**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)