

SENT VIA EMAIL OR FAX ON  
Apr/14/2011

## True Resolutions Inc.

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

**DATE OF REVIEW:**

Apr/13/2011

**IRO CASE #:**

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

Anterior Approach-lumbar fusion, anterior instrumentation 2-3 vertebral segments - with 3 day inpatient stay

**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

Dr. – DDE: 12/09/10

Dr. Office Record: 11/12/10

MRI Lumbar Spine: 05/01/10, 11/08/10

MRI Lumbar Spine: 01/05/11

Dr. Office Records: 01/20/10, 01/06/11, 01/26/11, 03/18/11

Dr. Office Records: 03/18/11

Peer Reviews: 02/23/11, 03/17/11

**PATIENT CLINICAL HISTORY SUMMARY**

This male claimant reportedly injured his low back while at work on xx/xx/xx when he heard a pop in his low back. He underwent a left sided L5-S1 microdiscectomy in 01/10 with documented poor results including severe persistent low back pain, weakness and numbness involving his left lower extremity and peroneal region. His diagnosis is lumbar intervertebral disc disorder with axial back pain and a mildly spondylotic L5-S1 level. Postop lumbar MRIs performed on 05/01/10 and 11/08/10 revealed enhancing granulation tissue in the left lateral and left anterior epidural space adjacent to the left S1 and S2 nerve root sleeves. There are right foraminal protrusions at L3-4 and L4-5 levels that displace the right L3 and L4 nerve roots posteriorly causing mild stenosis of the right L3-4 and L4-5 foramen with enhancing annular fissures seen in the protrusions. On 01/06/11, Dr. documented that the 11/07/10 EMG/NCV study demonstrated left S1 radiculopathy. Lumbar spine x-rays from 02/01/11 revealed mild multilevel degenerative changes, bridging osteophytes in the thoracolumbar region and L5-S1 facet arthropathy and intervertebral disc narrowing. The 01/06/11 exam revealed positive straight leg raise testing with left calf atrophy along with left sided motor strength weakness and diminished sensation. The 03/18/11 office record indicated continued

symptoms now improved with the claimant performing regular exercise and strengthening. The 03/18/11 record indicated he “failed all attempts of conservative management” with only medications documented in the records. Authorization was requested to proceed with a lumbar fusion, anterior approach with anterior instrumentation of 2 to 3 segments and a 3 day inpatient stay.

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

The request for anterior approach lumbar fusion, anterior instrumentation, two to three vertebral segments with three day inpatient length of stay is not recommended.

The medical records provided support the claimant previously had surgery L5-S1. X-rays showed multilevel degenerative changes. No flexion instability or motion segment instability was documented. MRI showed postoperative changes, small disc protrusion.

It is not clear the claimant has recently failed conservative care with physical therapy, occupational therapy, stretch, strength, range of motion, modalities, chiropractic care, epidural steroid injections. It is not clear the claimant has failed all attempts at conservative care.

Given the above issues, given that there is no evidence of motion segment instability, no progressive neurologic deficit, based solely on the records provided, I cannot approve the surgery as medically indicated and necessary at this time.

The request is for anterior instrumentation and fusion of two to three vertebral segments. It is unclear the segments or the necessity of extending the fusion.

Given the above issues and consistent with evidence-based medicine and Official Disability Guidelines, the IRO reviewer cannot find the proposed surgery as medically indicated and necessary at this time. Further, it is not clear that psychosocial screening has occurred or that the claimant has addressed smoking cessation.

Official Disability Guidelines Treatment in Worker’s Comp, 16th edition, 2011 Updates: Low Back – Fusion/Length of Stay

**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)