**SENT VIA EMAIL OR FAX ON**
**Aug/04/2011**


# True Decisions Inc.

**An Independent Review Organization**
**2002 Guadalupe St, Ste A PMB 315**
**Austin, TX 78705**
**Phone: (512) 879-6332**
**Fax: (214) 594-8608**
**Email: rm@truedecisions.com**


## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**
Jul/28/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
Surgery, 3-5 days, Lumbar Anterior/Posterior Fusion L2-5

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**
MD board certified orthopedic surgery practicing neurosurgery

**REVIEW OUTCOME:**

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

[ X ] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**
OD Guidelines
1. Pre-authorization request 06/28/11
2. Pre-authorization reconsideration request 07/08/11
3. Initial spine surgery consultation and follow up notes Dr. 12/17/10 through 04/12/11
4. Physical therapy notes
5. MRI lumbar spine 11/01/10
6. Designated doctor evaluation Dr. 06/13/11
7. Utilization review determination 07/07/11 regarding request for authorization for spinal surgery/lumbar fusion
8. Utilization review determination 07/15/11 regarding reconsideration/appeal request

**PATIENT CLINICAL HISTORY SUMMARY**
The injured employee is a female whose date of injury is xx/xx/xx. Records indicate that she picked up a heavy box to hold a door back and has had severe pain ever since. She complains of low back pain with radiation to the left buttock and left lower extremity. MRI of

the lumbar spine performed 11/01/10 revealed multilevel degenerative changes. At L3-4 and L4-5 there are degenerative changes with prominent spinal stenosis. At L2-3 there is degenerative disc with disc bulge and protrusion which may contact the exiting nerve roots. X-rays of the lumbar spine were noted to show multilevel degenerative disc disease with severe disc desiccation. Records indicate the injured employee was treated conservatively with three to four sessions of physical therapy, medications, and epidural steroid injection on the left at L5 which provided no relief. The injured employee was recommended to undergo surgical intervention.

A request for anterior/posterior lumbar fusion L2-5 and three to five day inpatient admission was reviewed on 07/07/11 and it was determined the request did not meet medical necessity guidelines. The review noted that MRI dated 11/01/10 revealed degenerative changes at L3-4 and L4-5 with prominent spinal stenosis at these levels. There was degenerative disc at L2-3 with disc bulge and protrusion which may contact the exiting nerve roots. X-rays reportedly showed some multilevel degenerative disc disease with severe disc desiccation. Physical examination reported the injured employee to be 5'8" tall and 250 pounds. She ambulates with a forward stooped posture. She is unable to stand erect secondary to significant pain. She also has significant muscle spasm. There is no sensory loss, although the injured employee describes generalized leg heaviness when she ambulates. Current medications were listed as Zanaflex and Norco. Records indicate the injured employee had epidural steroid injection left L5 with no relief. The reviewer noted although the records indicated the injured employee had been referred for physical therapy and epidural steroid injections there was no comprehensive history of the nature and extent of conservative treatment completed to date. No flexion/extension films were submitted with evidence of instability of the lumbar spine. There was no detailed physical examination report indicating motor, sensory or reflex changes. There also was no pre-surgical psychological evaluation documented. As such medical necessity was not established.

A reconsideration/appeal request for surgery, 3-5 days, lumbar anterior/posterior fusion L2-5 was reviewed on 07/15/11 and it was determined that reconsideration request did not meet medical necessity guidelines. The reviewer noted that MRI of the lumbar spine documented at L3-4 and L4-5 prominent concentric spinal stenosis with almost complete obliteration of the cerebrospinal fluid surround the nerve roots. The injured employee was seen for complaints of back and leg pain. Examination revealed spasm and forward stooped posture. X-rays were noted to show multilevel degenerative disc disease with severe disc desiccation. The injured employee underwent 03/24/11 lumbar epidural steroid injection with no relief. A designated doctor evaluation was performed by Dr. on 06/13/11. Examination at that time revealed left ankle plantar and dorsiflexion strength of 4+/5, decreased sensation over all five toes of the left lower extremity, positive supine straight leg raise on the left, unable to perform heel toe walk and bilateral lower extremity reflexes were 1+. Dr. recommended decompression and fusion surgery as recommended by Dr. The injured employee has been treated with physical therapy and medications. Per peer to peer discussion with Dr. it was noted the injured employee has radicular symptoms, neurogenic claudication and multilevel spinal stenosis. It was noted that although the injured employee would be a candidate for multilevel lumbar decompression, based on Official Disability Guidelines she is not a candidate for fusion as there is no documentation of instability, and the request is non-certified.

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

Based on the clinical information provided, medical necessity is not established for the proposed anterior/posterior lumbar fusion L2-5 with 3-5 day inpatient stay. The injured employee is noted to have sustained a lifting injury to the low back on xx/xx/xx. Imaging studies revealed multilevel degenerative changes with prominent spinal stenosis at L3-4 and L4-5. At L2-3 there is degenerative disc with disc bulge and protrusion which may contact the exiting nerve roots. Dr. examination revealed no motor, sensory or reflex changes; however, designated doctor evaluation on 06/13/11 reported 4+/5 strength of left ankle plantar and dorsiflexion, with decreased sensation over all five toes of the left lower extremity

and positive supine straight leg raise on the left. It was also noted the injured employee was unable to perform heel toe walk. It is noted that the injured employee has radicular symptoms, with neurogenic claudication and multilevel spinal stenosis. No flexion extension films were documented with evidence of motion segment instability at any level of the lumbar spine. No pre-surgical psychological evaluation was provided addressing confounding issues and clearing the injured employee for surgical intervention. While decompression of the lumbar spine for spinal stenosis may be indicated, the proposed multilevel lumbar fusion is not indicated as medically necessary per ODG criteria. As such medical necessity is not established. The previous denials should be upheld on IRO.

**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**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] 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)**