

SENT VIA EMAIL OR FAX ON  
Feb/10/2011

## Independent Resolutions Inc.

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

**DATE OF REVIEW:**

Feb/10/2011

**IRO CASE #:**

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

Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L3-4, L4-5, and L5-S1

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a xx-year-old male who sustained an injury to his low back. The claimant stated he was he was continuously lifting 65 pounds. He awoke in the middle of the night with severe low back pain and was unable to move. The claimant saw the company doctor who returned him to work. The claimant went to an emergency room where he was given a prescription for medication and a diagnosis of sciatica. An MRI of his Lumbar spine on 06/29/10 revealed a posterior central, right paracentral disc protrusion measuring 4.38 millimeters with thecal sac impingement with right neural canal narrowing at L3-4 with mild spinal stenosis. There was a posterior central, left paracentral, posterolateral protruded herniated disc measuring 6 millimeters with thecal sac impingement, left neural canal and foraminal narrowing at L4-5 with moderate spinal stenosis and bilateral facet hypertrophy. At L5-S1 there was a posterior central, left paracentral disc protrusion measuring 4.89 millimeters with anterolisthesis and suggestion of spondylolysis and vacuum disc phenomenon with proximal left neural canal narrowing. The claimant underwent physical therapy and an epidural steroid injection without relief of his symptoms. He was referred to a physician. X-rays done in physician office on 11/23/10 included flexion/extension views and

revealed significant spinal unit collapse with anterior column lack of support at L3-4, L4-5 and L5-S1. His normal anterior column support measured 12 millimeters at L2-3, this decreased to 50 percent at L3-4 to 6 millimeters with facet subluxation and foraminal stenosis. At L4-5 it also decreased to 6 millimeters of anterior column support with facet subluxation and foraminal stenosis. At L5-S1 there was complete collapse with no anterior column support to 0 with bone on bone spondylosis with facet subluxation and lateral recess stenosis. On examination the claimant had a positive spring test, positive extensor lag and positive sciatic notch tenderness bilaterally although worse on the left. There was a positive Flip test bilaterally, positive Lasegue's on the right at 45 degrees and a contralateral positive straight leg raise on the left at 75 degrees with pain front and back in right lower extremity. The claimant had a decreased knee jerk and ankle jerk on the right and absent posterior tibial tendon jerk bilaterally. He had paresthesias in the L4, L5 and S1 nerve root distribution on the right, weakness of the gastroc-soleus and tibialis anterior and extensor hallucis longus on the right with a positive extensor lag. Physician recommended surgery and the claimant underwent a psychological evaluation on 12/22/10 and was considered to be a fair to good risk for surgery. The proposed surgery was noncertified in two peer reviews.

The first peer review on 01/14/11 noncertified the surgery because on examination the claimant was noted to have motor and sensory deficits in the right lower leg and imaging studies showed pathology at L4-5 and L5-S1 on the left. While it appeared that the claimant might need a fusion at L5-S1 it was unclear why he needed fusion at L3-4 and L4-5.

The second peer review was done on 01/25/11 and noncertified the surgery as there was no documentation of a spinal fracture or dislocation to warrant a fusion. While the claimant might have had a spondylolisthesis at L5-S1 it was not established with flexion/extension x-rays. It was not established that the claimant had a history consistent with frank neurological compromise and therefore surgery was not indicated.

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

Lumbar laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of a bone growth stimulator at L3-4, L4-5, L5-S1 would not be considered medically necessary or appropriate based upon the records provided in this case.

If one looks towards the Official Disability Guidelines for lumbar spinal fusion, x-rays should demonstrate spinal instability. In this case, Physician has described flexion/extension radiographs with significant spinal unit collapse, anterior column lack of support at L3-4, L5, and L5-S1. Notes provided do not document significant instability with translation greater than 5 millimeters or angular change greater than 12 degrees.

Official Disability Guidelines require the spine pathology be limited to two levels. In this case, three levels are requested.

As there is no evidence of significant instability by flexion/extension radiographs, and the proposed level of fusion is greater than two levels, the proposed L3-4, L5, and L5-S1 laminectomy, discectomy, arthrodesis with cages, posterior instrumentation and implantation of bone growth stimulator would not be considered medically necessary or appropriate based upon the Official Disability Guidelines.

**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)