

SENT VIA EMAIL OR FAX ON  
Feb/22/2011

## Applied Resolutions LLC

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/17/2011

**IRO CASE #:**

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

L4, L5, S1 lumbar laminectomy, discectomy, arthrodesis with cages and posterior instrumentation

**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 female who sustained a work related injury to her low back when she slipped and fell. The claimant had an MRI of her lumbar spine on 11/14/08 that revealed a L4-5 disc protrusion impinging on the thecal sac, bilateral facet hypertrophy, anterior spurring and a disc bulge at L5-S1 with bilateral facet hypertrophy. It also revealed a posterior central left paracentral disc bulge L5-S1. The claimant had an EMG/NCV done on 12/04/08 that was consistent with an acute left L4-5 radiculopathy. She underwent a

designated doctor examination on 04/07/09 and was declared to have reached maximal medical improvement. She was given a 6% whole person impairment rating. She saw Dr. on 05/24/10 for an Independent Medical Evaluation. Dr. noted that the claimant had had radiofrequency facet rhizotomy which helped her for about 5 months and had an additional facet rhizotomy at left L2, L3, L4 and L5 on 12/16/09 with only 50% relief. On examination she had no palpable spasm, a muscle strength of 5/5, flexion of 70 degrees, extension of 20 degrees and reflexes of 1+ at both the knee and ankle bilaterally. Dr. recommended the claimant be instructed in the McKensie exercise protocol for the lumbar area, be weaned off narcotics and transitioned to Ultram. The claimant saw Dr. for a surgical consultation on 11/30/10. Dr. noted that the claimant had failed conservative treatment including an exercise program, medications, chiropractic and epidural steroid injections. X-rays of the claimant's lumbar spine taken in Dr. office including flexion-extension views revealed anterior column lack of support at L4-5 and L5-S1 with facet subluxation, foraminal stenosis and lateral recess stenosis with posterior column lack of support. L3-4 functional spinal unit measured 11 millimeters, L4-5 measured 4 millimeters for functional spinal collapse and L5-S1 measured 3 millimeters for functional spinal unit collapse. The claimant had a positive flip test bilaterally, a positive Lasegue's on the left at 45 degrees and a contralateral positive straight leg raise on the right at 75 degrees for anterior back and left lower extremity. The claimant had an absent ankle jerk on the left and absent posterior tibial tendon jerks bilaterally. She had paresthesias in the L5-S1 nerve root distribution on the left and weakness of the gastroc soleus on the left without atrophy. Dr. recommended L4, L5, S1 lumbar laminectomy, discectomy, arthrodesis with cages and posterior instrumentation. The surgery was noncertified on two peer reviews.

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

The L4, L5, S1 lumbar laminectomy, discectomy, arthrodesis with cages and posterior instrumentation is not medically necessary based on review of this medical record.

This is a xx-year-old woman who has back and leg complaints. She has undergone an EMG documenting a right S1 radiculopathy and she has undergone an MRI documenting disc bulges lower lumbar spine. She was seen by Dr. on 05/24/10 who felt that she could be treated conservatively. She has been seen by Dr. on 11/30/10 and he described what he felt to be loss of anterior column support with functional spinal collapse. The Official Disability Guidelines document the use of lumbar spine fusion in claimants who have structural instability in terms of angular or translational or abnormal motion on flexion/extension stress lateral X-rays; that is not documented in this case. Therefore the requested fusion surgery is not medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 16<sup>th</sup> edition, 2011 Updates. Low Back:

Lumbar fusion:

Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined below. After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment.

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion include all of the following:

- (1) All pain generators are identified and treated; &
- (2) All physical medicine and manual therapy interventions are completed; &
- (3) X-ray demonstrating spinal instability and/or MRI, Myelogram or CT discography

demonstrating disc pathology; &

(4) Spine pathology limited to two levels; &

(5) [Psychosocial screen](#) with confounding issues addressed.

(6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

**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)