

SENT VIA EMAIL OR FAX ON  
Mar/12/2011

## True Resolutions Inc.

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

**DATE OF REVIEW:**

Mar/11/2011

**IRO CASE #:**

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

L4/5 and L5/S1 360 Fusion Bilateral and 2 day LOS Inpatient Stay

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

Board Certified Orthopedic Surgeon, Practicing Neurosurgeon

**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 injured employee is a female who injured her low back picking up a heavy object. She had subsequent injury in xxxx and then was involved in a motor vehicle accident in xxxx when she was rear-ended. MRI of the lumbar spine dated 02/28/07 revealed a small left paracentral disc protrusion at L5-S1 with canal and foramina well maintained. Remaining disc spaces were normal in appearance. Repeat MRI of the lumbar spine done 01/29/10 reported resorption of the previous left paramedian and posterolateral protrusion of disc material at the L5-S1 level. There are now small annular fissures in the outer annular ligament at L5-S1 and there is disc desiccation. The annular fissures are immediately adjacent to the left S1 nerve root at its exit zone. Injured employee complains of low back pain with intermittent right lower extremity pain. Injured employee was treated conservatively with physical therapy and chiropractic care. Injured employee also underwent lumbar facet block. Discogram of the lumbar spine was performed on 08/26/10. Flexion extension views of the lumbar spine dated 07/29/10 revealed no significant dynamic instability with no evidence of spondylosis or spondylolisthesis. Injured employee was seen at clinic on 02/22/10 for new patient evaluation. Physical examination reported the injured employee to be x'x½" tall and xxx.x pounds. Injured employee rises from seated position to standing without difficulty. She ambulates with a normal gait using no assistive devices. There is no overlying erythema, ecchymosis or other skin changes along the length of her back. She has no tenderness to palpation in the midline along the cervical and thoracic spine. However in

the lower lumbar region in the midline and in paraspinal musculature there is some generalized muscular tenderness to palpation. Extension of her back seems to exacerbate her pain as does extension with lateral rotation more pronounced on the right than left. Manual motor exam revealed 5/5 strength throughout. Sitting root test was negative. Reflexes were symmetric at the knees and ankles. There was no sensory disturbance to gross dermatomal testing. Supine straight leg raise was negative. Faber test was unremarkable for concordant reproduction of low back pain. Injured employee was recommended to undergo two level lumbar fusion at L4-5 L5-S1 with 360 fusion.

A request for L4-5 and L5-S1 360 fusion bilateral and two-day inpatient stay was reviewed by Dr. on 01/21/11. Dr. determined the request was non-authorized for medical necessity. Dr. noted that the injured employee has no evidence of instability on MRI or x-rays and fusion would not be supported.

A reconsideration request was reviewed by Dr. on 02/03/11 and Dr. determined the request to be non-authorized. Dr. noted that the injured employee is stated to smoke one pack of cigarettes per day. Examination was noted to be negative for any radicular symptoms with normal motor and sensory exams and negative straight leg raise. Dr. noted the injured employee underwent two sets of facet blocks after which the pain was worse. Flexion extension views of the lumbar spine documented no significant dynamic instability with no evidence of spondylosis or spondylolisthesis. Dr. determined that there was no objectified instability of the lumbar spine to support the request for 360 fusion of L4-5 and L5-S1. It was noted that the L4-5 disc is only subtly degenerative as stated on discogram and the L5-S1 is only mildly degenerative. The clinical examinations document no objectified radiculopathy or evidence of nerve root compression by diagnostic imaging with no sensory, motor or neurologic deficit. Dr. noted that therefore without clinical instability, radiculopathy 360 fusion at L4-5 and L5-S1 would not be medically indicated or supported by peer-reviewed guidelines.

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

Based on the clinical information provided, the request for L4-5 and L5-S1 360 fusion bilateral and two-day LOS inpatient stay is not supported as medically necessary. Injured employee is noted to have sustained a lifting injury to the low back on xx/xx/xx. Injured employee had subsequent injury in xxxx and again in xxxx secondary to a motor vehicle collision. Most recent MRI dated 01/29/10 revealed resorption of previous left paramedian and posterolateral protrusion of disc material at L5-S1. There are now small annular fissures seen in the outer annular ligament. The foramina are broadly patent, the canal is broadly patent. Radiology report dated 07/29/10 indicated that x-rays of the lumbar spine noted some slight disc space narrowing at L5-S1. Flexion extension views showed no significant dynamic instability and no spondylolysis or other spondylolisthesis was identified. Injured employee has no neurologic deficits on clinical examination with intact motor, sensory and reflex examination. As such, medical necessity is not established for the proposed surgical procedure of 360 fusion bilateral L4-5 and L5-S1.

#### **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)