

SENT VIA EMAIL OR FAX ON  
Sep/13/2011

## Independent Resolutions Inc.

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

**DATE OF REVIEW:**  
Sep/13/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Inpatient L5/S1 lumbar laminectomy, discectomy and fusion with instrumentation with two (2) days length of stay (LOS)

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

OD Guidelines

1. Notice of utilization review findings 08/22/11 recommending non-authorization of inpatient L5-S1 lumbar laminectomy, discectomy, fusion with instrumentation for 2 days length of stay
2. Notice of utilization review findings 08/29/11 recommending non-authorization reconsideration of inpatient L5-S1 lumbar laminectomy, discectomy and fusion with instrumentation with 2 day LOS
3. Notice of employee's work related injury or illness
4. MRI lumbar spine 12/28/10
5. Lumbar spine x-rays 12/28/10
6. Lower EMG/NCV 03/30/11
7. Office notes Medical Clinic 01/03/10-08/23/11
8. New patient surgical consultation and follow-up notes Dr. 01/11/11-06/14/11
9. Physical therapy therapeutic exercises / modality flow sheet and charge sheet
10. Clinical interview psychological evaluation 07/29/11

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male who was injured on xx/xx/xx. According to the notice of employee's work related injury / illness, the injured employee was providing security in the offender's dining hall, and as he was going around the rail dividing the hall slipped but did not fall. X-rays of lumbar spine on 12/28/10 reported degenerative disc disease with mild disc space narrowing at L5-S1 with no acute fracture or subluxation seen. MRI of lumbar spine on 12/28/10 revealed a right paracentral disc protrusion causing right lateral recess narrowing and displacement of thecal sac and descending nerve roots with proximal right neural foraminal narrowing at L5-S1. There was left neural foraminal narrowing from foraminal disc protrusions at L3-4 and L4-5. Electrodiagnostic testing performed on 03/30/11 reported indication of mild acute L5 and S1 radiculopathy with S1 root being more involved on left with no apparent involvement of the L2, L3 or L4 roots. Records indicate the injured employee initially was treated conservatively with physical therapy. The injured employee was seen for surgical consultation on 01/11/11 with chief complaint of back pain and left lower extremity pain. X-rays of lumbar spine including flexion / extension views were noted to show clinical instability with 9mm of forward and backward translation at L5-S1. Physical examination at that time revealed mild paravertebral muscle spasm, possible extensor lag, positive spring test L5-S1, positive sciatic notch tenderness in left only. There was a positive flip test on left, possible Lasegue's at 45 degrees, positive Braggard's, absent posterior tibial tendon jerk bilaterally, decreased ankle jerk on left, weakness of gastrocsoleus on left, and paresthesias of L5 and S1 nerve root distribution on left. The injured employee was seen in follow-up on 02/22/11 and was noted to have had 9 sessions of physical therapy with little if any improvement. Physical examination was unchanged. The injured employee was recommended to complete physical therapy. Office visit note dated 06/14/11 indicates the injured employee continues with back pain and left leg pain. He is noted to have failed conservative treatment over the last 6 months to include exercise program, medications, and epidural steroid injections. The injured employee is noted to have seen designated doctor on 05/05/11 and was determined not to have reached maximum medical improvement. The injured employee was recommended to undergo decompression and instrumented arthrodesis with reduction of subluxation at L5-S1. A presurgical psychological evaluation was performed on 07/29/11, and the injured employee was considered to be a fair risk for surgical procedure from psychological perspective.

A preauthorization request for inpatient L5-S1 lumbar laminectomy, discectomy, fusion with instrumentation and 2 day LOS was reviewed by Dr. . A notice of utilization review findings dated 08/22/11 recommended non-authorization of the proposed surgical procedure and inpatient stay. Dr. noted there were several concerns regarding the requested procedure including 1) pain is reported to be in left lower extremity, but the MRI report indicates pathology at the L5 level is predominately on the right; decision for fusion (for instability) was made on flexion / extension films with interpretation apparently done by requesting surgeon, and it would be cleaner if such films were interpreted by independent observer (i.e., radiologist); the request is for additional level (63035), but that level is not identified, nor is there any evidence in the materials submitted for review of another level of pathology needing surgery.

An appeal request for inpatient L5-S1 lumbar laminectomy, discectomy, and fusion with instrumentation with 2 day LOS was reviewed by Dr.. A notice of utilization review findings dated 08/29/11 recommended non-authorization of the reconsideration request. Dr. noted the injured employee was injured when he slipped but did not fall. He has already undergone physical therapy, but there are no details of physical therapy; however, it is noted the injured employee did not improve with physical therapy. There are no other indications of conservative treatment that the injured employee has received. There was no comprehensive description of injured employee's symptomatology, physical neurologic examinations are inconclusive in identifying the pain generators. It was noted that positive Spurling's test, sciatic notch test, Faber's, extensor lag, absent posterior tibial tendon jerks bilaterally, and absent ankle jerk on left were noted, but these were not significant in

identifying the pain generators and do not indicate any instability. MRI performed 12/28/10 noted right paracentral disc protrusion causing right lateral recess narrowing at L5-S1 and left neural foraminal narrowing from L3-4 and L4-5 per the radiologist report. The requesting physician indicates there is extruded disc fragment and herniation at L5-S1. The presence of tears is consistent with findings not traumatic in pathology and often found as incidental findings on MRI. The requesting physician indicates there is clinical instability, but this is not confirmed. Dr. agreed with previous reviewing physician and upheld the denial of request.

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

Based on the clinical information provided, the proposed inpatient L5-S1 lumbar laminectomy, discectomy, and fusion with instrumentation and 2 day inpatient length of stay is indicated as medically necessary. The injured employee is noted to have sustained an injury to low back when he slipped on wet floor but did not fall. Imaging studies revealed a right paracentral disc protrusion causing right lateral recess narrowing and displacement of the thecal sac and descending nerve roots with proximal right foraminal narrowing at L5-S1. There is left neural foraminal narrowing from foraminal disc protrusions at L3-4 and L4-5. Electrodiagnostic testing reported mild acute L5 and S1 radiculopathy with S1 root being more involved on left. There is evidence of instability on flexion/extension views. A previous reviewer noted that there was no radiologist's report; however, it appears that the films were performed in Dr. office. As an orthopedic spinal surgeon, Dr. certainly is more than qualified to interpret radiology studies. The injured employee is noted to have failed conservative treatment including physical therapy, medications and epidural steroid injections. On examination there were motor and sensory deficits in left lower extremity in L5-S1 distribution, with hypoactive ankle jerk on left. The patient was cleared for surgical intervention from psychological perspective. Noting that the patient has objective evidence of significant L5-S1 pathology with motion segment instability; EMG evidence of left sided radiculopathy; physical examination findings consistent with diagnostic testing; and failure of conservative care, the proposed surgical procedure is indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

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

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**