

# Applied Assessments LLC

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jul/26/2012

**IRO CASE #:**

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

ALIF L4-S1, post lumbar decompression with fusion and pedicle screw instrumentation with 2 days LOS

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

Neurosurgery

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 07/09/12

Utilization review determination dated 05/28/12

Utilization review determination dated 06/28/12

MRI lumbar spine 08/12/11

MRI lumbar spine 10/13/11

Clinical records Dr.

Initial behavioral medicine consultation dated 12/19/11

Individual psychotherapy notes

Clinical records Dr.

Procedure report 04/31/12

Radiographic report lumbar spine 03/12/12

Texas Department of insurance division worker's compensation decision and order 04/10/12

Neuropsychological evaluation 04/17/12

Presurgical psychological evaluation 05/07/12

Designated doctor's evaluation 06/07/12  
DWC form 69 06/07/12  
Radiographic report lumbar spine 06/08/12  
Fax cover sheet 06/28/12  
Letter of appeal dated 07/09/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained work related injuries on xx/xx/xx. Records indicate the claimant was referred for MRI of lumbar spine on 08/12/11 and notes 2 mm disc bulge at L4-5 with disc narrowing, ligamentum flavum, and facet hypertrophy causing mild central canal stenosis and mild right foraminal stenosis and moderate left foraminal stenosis. At L5-S1 there is 3 mm disc bulge that flattens the thecal sac without causing central stenosis. Disc bulge, disc narrowing, and facet hypertrophy causes severe bilateral foraminal stenosis at L5-S1. At L3-4 there is a 1 mm bulge which abuts the thecal sac. A repeat MRI of lumbar spine was performed on 10/13/11 and notes at L4-5 there is broad based posterior disc protrusion + hypertrophy of facet joints producing bilateral subarticular recess stenosis and moderate to severe bilateral foraminal stenosis. At L5-S1 there is 3-4 mm retrolisthesis with 5 mm broad based disc protrusion / extrusion annular fissure plus corresponding end plate osteophyte. There is bilateral subarticular recess stenosis and severe bilateral foraminal stenosis with displacement of L5 nerve roots.

On 10/31/11 the claimant was seen by Dr.. The claimant reported slipping and falling off truck with acute onset of low back pain with radiation mainly into bilateral lower extremities left greater than right. He is status post previous lumbar laminectomy in 1988 with variation of symptomatology at that time. He is reported to have undergone physical therapy without benefit. Current medications include Lexapro, Hydrocodone and Trazadone. He is noted to be a smoker. On physical examination he is 5'6" tall and weighs 180 lbs. He has 4/5 strength in tibialis anterior, EHL and gastrocnemius complex on left otherwise 5/5 throughout. Deep tendon reflexes were 1+ in left ankle, otherwise 2+ and symmetrical. Gait was antalgic. He has difficulty with toe walking, less difficulty with heel walking, and no difficulty with tandem walk. Straight leg raise is positive bilaterally at 50 degrees. Sensory exam reveals hypoesthetic regions in L5 and S1 distributions on the left. The claimant is opined to have recurrent lumbar radiculopathy with recurring disc herniations at L4-5 and L5-S1. He is further reported to have discogenic pain at L4-5 and L5-S1. He has retrolisthesis of L5 on S1. He subsequently recommended the claimant be referred for epidural steroid injection.

On 12/19/11 the claimant underwent behavioral medicine evaluation. The claimant had 21 on BDI-II indicating moderate depression and BAI was 48 indicating severe anxiety. He subsequently was recommended to undergo neuropsychological evaluation and 6 sessions of individual psychotherapy.

On 01/06/12 the claimant was seen by Dr. who recommended caudal epidural steroid injection performed on 04/31/12 without benefit.

On 02/20/12 the claimant was seen in follow-up by Dr. who recommended anterior lumbar interbody fusion at L4-5 and L5-S1 with posterior lumbar decompression, posterolateral fusion with pedicle screw instrumentation at L4-5 and L5-S1.

On 03/12/12 the claimant was referred for lumbar flexion / extension radiographs. This study shows no evidence of instability and notes reduced interspace at L5-S1.

The record contains Texas department of insurance division of worker's compensation decision and order dated 04/10/12 noting compensable injury is limited to diagnosis of thoracic sprain and doesn't extend to include bulging disc of cervical spine, bulging disc of lumbosacral spine, aggravation of preexisting degenerative spinal disease of cervical and lumbosacral spine regions or contusion.

On 04/17/12 the claimant underwent a comprehensive neuropsychological evaluation. Of

note, the claimant is reported to have demonstrated core effort. He notes there is evidence of significant cognitive impairment exceeding that expected for the given mechanism of injury. He notes there is no evidence of intracranial injury. The evaluator notes the test effort was very poor and unlikely this neuropsychological evaluation provided valid evidence of neurocognitive functioning and noted based on present findings diagnosis of pseudodementia should be considered.

A pre-surgical psychological evaluation was performed on 05/07/12; it is noted that he had scored a 30 on the BDI-2 indicating severe depression and that his BAI was 29 reflecting severe anxiety. Despite this the evaluator opines that the claimant is an appropriate candidate for surgical intervention. There is an additional recommendation for him to participate in individual psychotherapy.

The record contains a designated doctor evaluation performed by Dr. on 06/07/12. Dr. Mayorga notes that the claimant has painful range of motion in all directions, motor strength was graded as 5/5, neurosensory is grossly intact, there's mild to moderate tenderness to palpation over the lumbosacral spine. He was able to heel toe walk, walk on his heels, and walk on his tip toes with moderate difficulty. Straight leg raise was reported to be positive bilaterally, patellar and ankle reflexes are present Dr. finds the claimant to be at clinical maximum medical improvement and assessed a 0% impairment rating

On 07/08/12, the claimant was referred for repeat lumbar flexion extension radiographs which are reported which are unchanged.

On 06/28/12, a fax cover sheet addressed to Dr. reports that the claimant will require bilateral facetectomies at L4-5 and L5-S1 which would result in iatrogenic instability requiring a fusion procedure

The initial request was reviewed on 05/28/12. The evaluator notes that the claimant is positive to Waddell's non-organic physiologic signs indicative of psychiatric related findings and subsequently non-certified the surgical request.

The appeal request was reviewed on 06/28/12 the evaluator notes that the claimant has previously received of two 0% impairment ratings. He is noted to be a smoker. The patient has disc bulges at L4-5 and L5-S1. The evaluator notes that there's a lack of documentation of any instability to warrant a two level lumbar fusion procedure. He further reports that the claimant has been placed at maximum medical improvement with a 0% impairment rating by two providers. He reports there is documentation which includes a State Decision and Order that limits the compensable injury to the thoracic sprain. He notes that there's no recent documentation from the requesting provider to rebuke these claims and therefore the request is non-certified.

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

The request for ALIF L4-S1, posterior lumbar decompression with fusion and pedicle screw instrumentation with two days LOS is not supported as medically necessary the submitted clinical records indicate that the claimant is reported to have slipped and fallen off a truck on the date of injury of xx/xx/xx. The claimant's MR imagery indicates the presence of disc bulges at L4-5 and L5-S. Later imaging suggests the presence of a retrolisthesis of L5 on S1 without instability. The claimant subsequently received physical therapy and has received at least one epidural steroid injection. The claimant has been under the care of Dr. The claimant was referred for a initial behavioral medicine consultation on 12/19/11, which indicated that the claimant required individual psychotherapy. Subsequent follow-up notes indicate that the claimant still had continued low back pain without improvement despite conservative management. The record includes lumbar flexion extension radiographs which showed no evidence of instability at any level. The record contains a Decision and Order which limits the compensable injury to the thoracic sprain and all other conditions involving the cervical and lumbar spine have been found not to be compensable. The record includes a

neuropsychological evaluation dated 04/17/12, which notes there was a language barrier and the validity of the test is unclear. The evaluator notes that there is a potential for a diagnosis of pseudodementia. The claimant was seen for pre-surgical psychological evaluation on 05/07/12 the claimant is noted to have grossly elevated BDI-2 and BAI in the severe ranges but yet is found to be a suitable candidate for surgical intervention. The claimant was ultimately seen by designated doctor on 06/07/12 and was provided a 0% impairment.

The totality of the clinical information presented indicates that the claimant is not a candidate for the performance of the two level lumbar fusion. Per the state Decision and Order the compensable injury is limited to the thoracic spine and therefore surgical intervention as related to the work place would not be reasonable or medically necessary treatment for the compensable injury. In addition to this the claimant clearly does not meet Official Disability Guidelines criteria for performance of this procedure. From a psychological perspective, the claimant is an exceedingly poor candidate for surgical intervention noting grossly elevated levels of depression and anxiety and a neuropsychological evaluation that suggests pseudodementia. It is unclear how the evaluating psychologist could reach a determination that the claimant was a suitable candidate for surgery in the presence of these findings. In addition to this the claimant has no objective evidence on physical examination of instability at either of the requested surgical levels. There is no data to suggest that the claimant requires an exceedingly wide decompression in the performance of this procedure if approved that would necessitate a fusion procedure. It is further noted that the claimant was seen by designated doctor Gilbert Mayorga on 06/07/12. Dr. independent examination finds no substantive findings of neuro compromise on physical examination. The claimant is noted to have diffuse tenderness without objective findings of motor strength loss, or loss of relevant reflexes or sensory abnormalities. Therefore based upon the totality of the submitted clinical information the claimant is not a candidate per Official Disability Guidelines for the requested procedure and the prior utilization review determinations are upheld.

**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**