

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/05/2012

**IRO CASE #:**

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

Decompression discectomy at L4-L5 and L5-S1 and instrumented arthrodesis at L5-S1 with 2-day inpatient hospitalization

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

M.D., Board Certified Orthopedic Surgeon, Spine 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**

Official Disability Guidelines and Treatment Guidelines  
Adverse Determination Letters, 11/30/11, 12/14/11  
Physician reviews, 11/13/11, 12/08/11  
Dr. 08/23/11, 09/27/11, 09/26/11, 12/07/10, 11/16/10, and 10/05/10  
Psychological evaluation 11/08/11  
CT myelogram of lumbar spine 09/13/11  
MRI lumbar spine 07/27/10  
Dr. 09/24/10, 08/06/10, 06/28/10, 05/11/10, 05/02/10, 04/23/10, 04/14/10, and 04/07/10  
Designated doctor evaluation 06/08/11  
EMG/NCV 03/09/11  
DWC form 69 10/15/10  
Designated doctor evaluation 10/15/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who injured his low back while pulling on wrench to straighten mud flap bracket. He developed low back pain with radiation to right lower extremity. MRI of lumbar spine from 07/07/10 shows L4-5 circumferential disc bulge contacting the ventral thecal sac, annular tears at L3-4 and L4-5 on left, disc desiccation at L3-4 and L4-5. L5-S1 is unremarkable. EMG/NCV studies showed evidence of chronic L5-S1 radiculopathy on right. Dr. designated doctor on 06/08/11, saw the claimant. He is 6 feet tall and weighs 213 lbs. Straight leg raise was positive. Sensation was normal. Reflexes were intact. Motor strength was noted to be intact. He is noted to have 2/8 Waddell signs. Claimant was diagnosed with lumbago. Discography was not approved. CT myelogram of the lumbar spine was recommended. He has a positive spring test at L5-S1, positive extensor lag, positive sciatic notch test. CT myelogram from 09/13/11 notes broad based disc herniation with abutment at

both L4 nerve roots in the neural foramina with no significant spinal stenosis a broad based disc herniation at L5-S1 with moderate bilateral foraminal stenosis and abutment of both L5 nerve roots. He remains symptomatic with primarily left leg pain.

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

This patient has evidence of disc protrusions at L4-5 and L5-S1 without evidence of compromise of nerve root filling on CT myelography. There is clear divergence in serial physical examinations with designated doctor evaluation noting no significant evidence of neurologic compromise. The records provided for this review do not indicate the claimant has any instability at L5-S1 level that would warrant fusion procedure. There is no indication for arthrodesis. Decompression discectomy at L4-L5 and L5-S1 and instrumented arthrodesis at L5-S1 with 2-day inpatient hospitalization is not medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

**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)**