

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jul/08/2013

**IRO CASE #:**

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

Transforaminal lumbar interbody fusion with expidum bullett with wiltse approach

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

Board Certified Orthopedic Surgery

**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 an independent review organization dated 06/17/13  
Receipt of request for IRO dated 06/18/13  
Utilization review determination dated 04/25/13  
Utilization review determination dated 05/21/13  
Clinical note dated 08/01/12  
Clinical records dated 08/13/12, 08/30/12, 10/04/12, 10/24/12, 11/21/12, 12/19/12, 01/16/13, 02/14/13, 03/14/13, 04/11/13, and 05/09/13  
Physical therapy evaluation dated 08/20/12  
Physical therapy treatment records  
MRI of the lumbar spine dated 10/15/12  
MRI of the right wrist dated 10/30/12  
Clinical records dated 11/13/12, 01/21/13, 02/19/13, 04/15/13, and 06/17/13  
Clinical notes dated 12/10/12, 02/04/13, 03/18/13, and 05/02/13  
Procedure report, trigger thumb injection dated 12/19/12  
Procedure report, lumbar epidural steroid injection dated 01/09/13  
Behavioral health evaluation dated 04/17/13  
Photocopies of lumbar radiographs, flexion and extension views, undated

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. It is reported that on the date of injury she stepped on a rock and twisted her right ankle

falling forward injuring her right arm, right knee, and back. The claimant was initially seen where she was noted to have right wrist pain. She was noted to have abrasions of both knees. She had decreased lumbar range of motion. There was tenderness at the paraspinal musculature at L4 and L5. The claimant was initially diagnosed with a lumbar strain, Colles' fracture of the right wrist, scaphoid fracture of the right wrist, abrasion of the left knee, and contusions of the left knee. On 08/13/12, the claimant was seen. She presents with complaints of right wrist pain. She is noted to have a scaphoid fracture and was placed in a splint. She complains of pain in the left lumbosacral area extending down to the posterior aspect of her leg. It is reported that parallel back pain was an aggravation of preexisting symptoms. Records indicate that the claimant was referred for physical therapy. When seen in follow up on 08/30/12, she continues to have pain in her back and left leg, more back pain than left leg pain extending all the way down her leg to the bottom of her foot. She is reported to have numbness in the same distribution. On examination, she is reported to have intact motor sensory, and reflexes. The claimant was ultimately referred for a MRI of the lumbar spine on 10/15/12. This study notes no significant abnormalities from L1-2 through L4-5. At L5-S1, there is a posterior annular fissure with asymmetric disc bulge to the left which does not result in canal stenosis. It is noted that there is some mild bilateral neuroforaminal stenosis. The asymmetric bulge towards the left appears to abut the exiting left L5 nerve root. There is mild facet arthrosis. The claimant was seen on 11/13/12. At this time, she has objective findings of a left lower extremity radiculopathy and was subsequently recommended to undergo an L5-S1 transforaminal epidural steroid injection. On 12/10/12, the claimant was seen. She continues to have pain with radiation down to the left lower extremity. She is noted to have markedly limited lumbar range of motion. She is reported to have 5/5 strength in the lower extremities. Deep tendon reflexes are 2/4 bilaterally. Straight leg raise was negative bilaterally. recommends the performance of an epidural steroid injection. He further notes that the patient may eventually require a surgical intervention for transforaminal fusion at L5-S1. On 01/09/13, the claimant underwent a lumbar epidural steroid injection which did not provide any substantive relief. The claimant was subsequently recommended to undergo a transforaminal lumbar interbody fusion. Records indicate that on 04/17/13, the claimant was referred for a behavioral health evaluation. This is a very limited report and provides no supporting documentation. Per the evaluator, PHD, the claimant was opined to have no psychopathology. The claimant was referred for lumbar flexion and extension radiographs which show no forward subluxation at L5 on S1 but do indicate evidence of disc space collapse.

The initial review of the request was performed on 04/25/13. The reviewer non-certified the request. The evaluator and neurosurgeon note that the claimant does not meet criteria per Official Disability Guidelines as there is no evidence to spinal instability and as such, the request did not meet Official Disability Guidelines.

The appeal request was performed on 05/21/13. The reviewer again finds no evidence of instability and as such, he notes that the claimant does not meet Official Disability Guidelines treatment recommendations.

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

The claimant is a female who is reported to have sustained work related injuries to her low back on xx/xx/xx. The records would indicate that the claimant sustained multiple injuries including the right wrist, knee, and low back. The claimant has been treated conservatively with oral medications and physical therapy and a single lumbar epidural steroid injection without benefit. The claimant exhibits findings of a left lower extremity radiculopathy. Imaging studies have indicated a loss of disc height at L5-S1 with no evidence of instability on the submitted flexion and extension views. The claimant has undergone a preoperative psychiatric evaluation which provides only limited information and no supporting documentation for the conclusion achieved by the evaluator. Based upon the data provided, this reviewer would concur with the previous determinations. There is no indication that the claimant has instability at the L5-S1 level and therefore, 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:**

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)