



CompPartners Final Report



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO #: _____
MDR #: M2-06-1094-01
Social Security #: _____
Treating Provider: William Donovan, MD
Review: Chart
State: TX
Date Completed: 6/29/06

Review Data:

- **Notification of IRO Assignment dated 4/5/06, 1 page.**
- **Receipt of Request dated 4/5/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 3/17/06, 2 pages.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Fax Cover Sheet dated 4/6/06, 1 page.**
- **Non-Authorization After Reconsideration Notice dated 2/27/06, 1 page.**
- **Non Authorization Notice dated 2/7/06, 1 page.**
- **Request for Preauthorization for Surgery dated 2/2/06, 1 page.**
- **Chart Note dated 1/18/06, 1 page.**
- **Procedure Note dated 12/7/05, 3 pages.**
- **Lumbar Discogram dated 9/20/05, 2 pages.**
- **Nerve Conduction Study dated 8/30/05, 2 page.**
- **Final Report dated 5/17/05, 1 page.**

Reason for Assignment by TDI: Determine the appropriateness of the previously denied request for anterior interbody fusion at L3-L4, L4-L5 and L5-S1; retroperitoneal exposure and discectomy L3-4, L4-5, and L5-S1; anterior interbody fixation L3-L4, L4-L5, and L5-S1, posterior decompression L5-S1; Transverse process fusion L3-L4, L4-L5, L5-S1; posterior internal fixation L3-S1, bone graft, allograft; bone graft, autograft in situ; bone graft, autograft, iliac crest, bone marrow aspirate.

Determination: UPHELD - previously denied request for anterior interbody fusion at L3-L4, L4-L5 and L5-S1; retroperitoneal exposure and discectomy L3-4, L4-5, and L5-S1; anterior interbody fixation L3-L4, L4-L5, and L5-S1, posterior decompression L5-S1; Transverse process fusion L3-L4, L4-L5, L5-S1; posterior internal fixation L3-S1, bone graft, allograft; bone graft, autograft in situ; bone graft, autograft, iliac crest, bone marrow aspirate.

Rationale:

Patient's age: 42 years

Gender: Male

Date of Injury: ____

Mechanism of Injury: Not provided for review.

Diagnoses: Status post intradiscal electrothermal annuloplasty procedure L3-4 and L5-S1, 12/7/05; status post knee surgery with ligament repairs and cartilage removal, 1/13/06.

The claimant underwent an intradiscal electrothermal annuloplasty procedure at L3-4 and L5-S1 on 12/7/05 without any relief whatsoever. Dr. Henderson recommended an anterior total discectomy, interbody fusion and interbody fixation of L3-4, L4-5 and L5-S1, posterior decompression of L5-S1 via total laminectomy at L5, and transverse process fusion of L3-S1 with pedicle fixation and cross brace. A surgical request of 2/2/06 noted diagnoses of failed intradiscal electrothermal therapy (IDET) at L3-4 and L5-S1, disc disruption syndrome at L5-S1, a herniated nucleus pulposus at L5-S1, spondylosis and discogenic pain L3-4 and radiculopathy. This was denied by two prior reviews on 2/7/06 and 2/27/06 respectively. A stand up MRI of the lumbar spine was performed on 5/17/06. However, only page one of the report was provided. The impression was, at L2-3 and L3-4, greater than 2 mm broad based posterior protrusion, which mildly indented the sac. There was no central canal stenosis and no remarkable foraminal narrowing. The findings noted at L4-5 was greater than 2 mm broad based posterior protrusion mildly indenting the sac with slight right posterolateral accentuation with mild-to-moderate right foraminal narrowing without nerve root effacement and, at L5-S1, a broad based posterior protrusion mildly indenting the sac. In left lateral bending was a posterior annular tear and mild bilateral foraminal narrowing. Based on the records provided, the proposed surgery is not recommended as medically necessary. The claimant was now six months post intradiscal electrothermal annuloplasty procedure and had persistent symptomatology. The current request is to address the medical necessity for a three-level lumbar fusion. The records indicated that the claimant had degenerative disc disease with primarily discogenic pain. While the claimant's findings were noted, the proposed surgical intervention cannot be recommended as medically necessary. The documentation provided was limited following the 12/7/05 intradiscal electrothermal annuloplasty procedure. There was no documentation of further treatment post intradiscal electrothermal annuloplasty procedure and no documentation of a physical examination. There was also no evidence based documentation provided of any spinal instability in this claimant. In accordance with ACOEM Guidelines, the spinal fusion is not recommended in the absence of fracture, dislocation, tumor, infection or instability. Therefore, the reviewer agrees with the previous denial for the proposed lumbar fusion, and the determination will be upheld.

Criteria/Guidelines utilized: ACOEM Guidelines, 2nd Edition, Chapter 12.

Physician Reviewers Specialty: Orthopedic Surgery

Physician Reviewers Qualifications: Texas licensed M.D. and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.

Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, requestor, claimant and the Division via facsimile or U.S. Postal Service from the office of the IRO on this 29th day of June, 2006.

Signature of IRO Employee:

A handwritten signature in blue ink that reads "Lee-Anne Strang". The signature is written in a cursive style with a long horizontal line extending from the end of the name.

Printed Name of IRO Employee
Lee-Anne Strang
Senior PRN Supervisor
CompPartners

Surgical Considerations

ACOEM GUIDELINES, 2ND. EDITION. LUMBAR SPINE, Pg. 305-306

Within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. Disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation,

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back and leg symptoms, and nerve root dysfunction. The presence of a herniated disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Some studies show spontaneous disk resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens (metalloproteinases, nitric oxide, interleukin 6, prostaglandin E2) released from a damaged disk in the absence of anatomical evidence of direct contact between neural elements and disk material. Therefore, referral for surgical consultation is indicated for patients who have:

- Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise
- Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms
- Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair
- Failure of conservative treatment to resolve disabling radicular symptoms

If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms.

Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI 2). In addition, clinicians may look for Waddell signs during the physical exam.

Many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in the absence of progressive nerve root compromise. With or without surgery, more than 80% of patients with apparent surgical indications eventually recover. Although surgery appears to speed short to mid term recovery, surgical morbidity (recovery and rehabilitation time and effects) and complications must be considered. Surgery benefits fewer than 40% of patients with questionable physiologic findings. Moreover, surgery increases the need for future surgical procedures with higher complication rates. In good surgery centers, the overall incidence of complications from first time disk surgery is less than 1%. However, for older patients and repeat procedures, the rate of complications is dramatically higher. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity should be weighed and discussed carefully with the patient. Following surgery, exercise is much better than manipulation for rehabilitation.

A. Lumbosacral Nerve Root Decompression

Direct methods of nerve root decompression include laminotomy, standard discectomy, and laminectomy. Chemonucleolysis with chymopapain is an example of an indirect method. Indirect chemical methods are less efficacious and have rare but serious complications (e.g., anaphylaxis, arachnoiditis). Percutaneous discectomy is not recommended because proof of its effectiveness has not been demonstrated. Recent studies of chemonucleolysis have shown it to be more effective than placebo, and it is less invasive, but less effective, than surgical discectomy; however, few providers are experienced in this procedure because it is not widely used anymore. Surgical discectomy for carefully selected patients with nerve root compression due to lumbar disk prolapse provides faster relief from the acute attack than conservative management; but any positive or negative effects on the lifetime natural history of the underlying disk disease are still unclear. Given the extremely low level of evidence available for artificial disk replacement or percutaneous endoscopic laser discectomy (PELD), it is recommended that these procedures be regarded as experimental at this time.

B. Intradiskal Electrothermal Annuloplasty

Intradiskal electrothermal annuloplasty may show some advantages over discectomy, but IDET is operator dependent and not considered ready for wholesale use by the public. Early outcomes may exaggerate the efficacy of IDET because some who initially improve later deteriorate. In addition, studies of IDET have relied on diskography, a technique not well supported by the medical evidence.

C. Implantable Spinal Cord Stimulators

Implantable spinal cord stimulators are rarely used and should be reserved for patients with low back pain for more than six months duration who have not responded to the standard nonoperative or operative interventions.

D. Management of Spinal Stenosis

Spinal stenosis usually results from soft tissue and bony encroachment of the spinal canal and nerve roots. It has a gradual onset and usually manifests as a degenerative process after age 50. Evidence does not currently support a relationship with work. The surgical treatment for spinal stenosis is usually complete laminectomy. Elderly patients with spinal stenosis who tolerate their daily activities usually do not require surgery unless bowel or bladder dysfunction develops. Surgery is rarely considered in the first three months after onset of symptoms, and a decision to proceed with surgery should not be based solely on the results of imaging studies. Some evidence suggests that patients with moderate to severe symptoms may benefit more from surgery than from conservative treatment.

E. Spinal Fusion

Except for cases of trauma related spinal fracture or dislocation, fusion of the spine is not usually considered during the first three months of symptoms. Patients with increased spinal instability (not work related) after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. There is no scientific evidence about the long term effectiveness of any form of surgical decompression or fusion for degenerative lumbar spondylosis compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. It is important to note that although it is being undertaken, lumbar fusion in patients with other types of low back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the surgical group versus 14% "much better" in the nonfusion group (a 15% greater chance of being "much better") versus a 17% complication rate (including 9% life threatening or reoperation).

Table 12-8. (continued)

Clinical Measure	Recommended	Optional	Not Recommended
Surgical considerations	<p>Discuss surgical options with patients with persistent and severe sciatica and clinical evidence of nerve root compromise if symptoms persist after 4-6 weeks of conservative therapy (B)</p> <p>Standard diskectomy or microdiskectomy for herniated disk (procedures have similar efficacy) (B)</p>	Chymopapain, used after ruling out allergic sensitivity, acceptable but less efficacious than diskectomy to treat herniated disk (C)	<p>Disk surgery in patients with back pain alone, no red flags, and no nerve root compression (D)</p> <p>Surgery for spinal stenosis within the first 3 months of symptoms (D)</p> <p>Surgery for spinal stenosis when justified by imaging test rather than patient's functional status (D)</p> <p>Spinal fusion in the absence of fracture, dislocation, complications of tumor, or infection (C)</p>
Psychosocial factors	Social, economic, and psychological factors can alter patient's response to symptoms and treatment (B)	Referral for evaluation prior to surgical intervention (C)	Referral for extensive evaluation and treatment prior to exploring patient expectations or psychosocial factors (D)

A= Strong research-based evidence (multiple relevant, high-quality scientific studies).

B= Moderate research-based evidence (one relevant, high-quality scientific study or multiple adequate scientific studies).

C=Limited research-based evidence (at least one adequate scientific study of patients with low back complaints).

D=Panel interpretation of information not meeting inclusion criteria for research-based evidence.