



CompPartners Final Report



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

Claimant Name: _____
Texas IRO # : _____
MDR #: M2-07-0196-01
Social Security #: _____
Treating Provider: Deepak Chavda, MD
Review: Chart
State: TX
Date Completed: 12/1/06

Review Data:

- **Notification of IRO Assignment dated 10/17/06, 1 page.**
- **Receipt of Request dated 10/17/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 9/27/06, 2 pages.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Letter dated 9/13/06, 8/31/06, 2/15/06, 9 pages.**
- **Request for Preauthorization for Surgery dated 8/22/06, 1 page.**
- **Follow-up Examination dated 10/18/06, 9/15/06, 8/30/06, 8/9/06, 7/26/06, 6/21/06, 5/22/06, 4/24/06, 2/22/06, 2/21/06, 32 pages.**
- **Functional Capacity Evaluation (FCE) dated 5/4/06, 1 page.**
- **Functional Abilities Evaluation dated 5/4/06, 15 pages.**
- **Chart Note dated 8/16/06, 6/30/06, 2 pages.**
- **Caudal Epidural Steroid Block dated 6/19/06, 1 page.**
- **Initial Chart Note dated 5/26/06, 2 pages.**
- **Lumbar Spine MRI dated 6/23/03, 1 page.**
- **Examination dated 9/15/06, 7/26/06, 4/26/06, 4/24/06, 2/21/06, 19 pages.**
- **Required Medical Examination dated 2/23/06, 6 pages.**
- **Operative Report dated 3/2/06, 1 page.**

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for:

1. Anterior interbody fusion at L4-5.
2. Additional level, L5-S1.
3. Retroperitoneal exposure and discectomy at L4-5.
4. Additional level, L5-S1.
5. Anterior interbody fixation at L4-5.
6. Additional level, L5-S1.
7. Posterior decompression at L4-5.
8. Additional level, L5-S1.
9. Transverse process fusion at L4-5.

10. Additional level, L5-S1.
11. Posterior internal fixation at L4-S1.
12. Bone graft.
13. Allograft.
14. Bone graft.
15. Autograft in situ.
16. Bone graft autograft.
17. Iliac crest.
18. Bone marrow aspirate.
19. Cybertech TLSO.

Determination: UPHELD – the previously denied request for:

1. Anterior interbody fusion at L4-5.
2. Additional level, L5-S1.
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9. Transverse process fusion at L4-5.
10. Additional level, L5-S1.
11. Posterior internal fixation at L4-S1.
12. Bone graft.
13. Allograft.
14. Bone graft.
15. Autograft in situ.
16. Bone graft autograft.
17. Iliac crest.
18. Bone marrow aspirate.
19. Cybertech TLSO.

Rationale:

Patient's age: 53 years

Gender: Female

Date of Injury: ____

Mechanism of Injury: Slipped and fell, injuring the right shoulder, neck and nose.

Diagnoses:

Status post, 1996, right elbow transposition.

Status post, 02/13/03, right shoulder open decompression and partial rotator cuff repair, excision of distal clavicle.

Status post, 11/2004, anterior cervical discectomy and fusion at C4, C5 and C6.

This claimant had mild bilateral facet degenerative changes at L4-5 and L5-S1 and minimal partial pars defect bilaterally, at L5-S1 on the 06/23/03 MRI. The claimant was treated through the PRIDE program with minimal benefit. Serial examinations by Dr. Chavada, noted worsening of her cervical pain and right upper extremity pain with paresthesias. Physical examination findings revealed cervical tenderness and slightly limited range of motion in all planes. Lumbar spine examination revealed tenderness. There were no neurologic deficits noted. Dr. Henderson has been following the claimant for her lumbar complaints. Dr. Henderson's impression of the June 2003 lumbar MRI was that it showed mild bilateral facet degenerative changes at L4-5 and L5-S1 and a pars defect bilaterally, at L5-S1. Dr. Henderson recommended discography which was denied. On 05/22/06, Dr. Henderson noted the claimant had functional limitations in standing, walking and sitting. Dr. Henderson noted that flexion and extension films showed some slight retrolisthesis of L5 on S1, but otherwise good alignment and relatively good maintenance of disc space height. Examination findings revealed no motor, sensory or reflex loss. On 06/30/06, Dr. Henderson saw the claimant and documented 30 percent diminishment of her pain with the epidural steroid injection. The last office note provided by Dr. Chavada noted worsening of the claimant's complaints and loss of grip strength. The lumbar examination remained essentially the same. In review of the medical records, it is this reviewer's opinion that this claimant is not a surgical candidate. The medical records did not document any evidence of instability. There was no documentation of any neurologic compromise on examination. The records document that there was some question of whether or not this claimant was interested in returning back to work. The proposed surgical procedure is a significant procedure in terms of risk for complications long term. It is this reviewer's opinion that the requested procedure is not medically necessary or supported by the medical records provided for review.

Criteria/Guidelines utilized: TDI/DWC Rules and Regulations.
ACOEM Guidelines, 2nd Edition, Chapter 12.
Rothman and Simeone, The Spine, 5th Edition, Chapter 63, page 1030.

Physician Reviewers Specialty: Orthopedic Surgeon

Physician Reviewers Qualifications: Texas Licensed M.D. and is 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

CORPORATE OFFICE
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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 day of December 1, 2006.

Signature of IRO Employee:



Printed Name of IRO Employee

Lee-Anne Strang

Surgical Considerations

ACOEEM 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, 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).