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IRO REVIEWER REPORT

DATE OF REVIEW: 04/10/07

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Items in Dispute: 360 degree fusion, decompression with graft and instrumentation at L4-L5 and L5-S1 with a three (3) to four (4) day length of stay.

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

Texas License and currently on TDI DWC ADL.
Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Denial Upheld: 360 degree fusion, decompression with graft and instrumentation at L4-L5 and L5-S1 with a three (3) to four (4) day length of stay denied.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. MRI report cervical spine dated 08/25/05.
2. MRI report lumbar spine dated 10/03/05.
3. EMG/NCV study dated 11/01/05.
4. /Required reports by Dr. dated 11/17/05
& 08/17/06.
5. CT report cervical spine dated 06/14/06.
6. Medical records of Dr. dated 08/08/06 – 01/16/07.
7. Lumbar discography report dated 01/03/07.

INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):

The employee is a male who was reported to have been involved in a motor vehicle accident. The employee sustained injuries to his neck, low back, and right shoulder. The employee was operating a car in a parking lot, was semi-belted, and was struck from the rear by an SUV. The employee's car was knocked around; however, it did not deploy the airbag.

The employee was not taken to the emergency room, and the car was drivable after the accident but did have a dent in the rear. The employee reported to be unable to continue working and reported the injury.

The employee was seen by a physician at Medical Centers on the date of injury. He was evaluated and referred to physical therapy. The employee subsequently switched to chiropractic care.

The employee has undergone Cortisone injections to the shoulder. An MRI of the shoulder was reported to reveal a partial tear of the rotator cuff. An MRI of the lumbosacral spine revealed a 2 mm protrusion at L3-L4. At L4-L5, there was a 3-4 mm protrusion. At L5-S1, there was a 4-5 mm protrusion. An MRI of the cervical spine revealed a 2 mm protrusion at C4-C5, and at C5-C6 there was a 2 mm protrusion. At C6-C7, there was a 2-3 mm protrusion.

On 11/17/05, the employee was evaluated by Dr. who diagnosed the employee with a cervical strain and multiple small protrusions without radiculopathy. Dr. opined that the employee needed to be placed on an active exercise program, and that the employee had undergone four months of physical therapy. Dr. found the employee not to be a good surgical candidate, and he was not a good candidate for epidural steroid injections. Dr. further recommended that the employee not receive any additional chiropractic care. The employee was referred for electrodiagnostic studies on 11/01/05. These studies of the lower extremities found no evidence of a lumbar radiculopathy.

The employee was subsequently referred for a CT scan of the cervical spine on 06/14/06. This study reported normal disc morphology at C2-C3 and C3-C4. At C4-C5, there was a posterior central broad-based protrusion measuring 2.3 mm. Mild ventral thecal sac deflection was present. Residual canal diameter was 9-10 mm. The facet joints were normal, and there was no foraminal stenosis. At C5-C6, there was a bulging annulus measuring 2 mm. Uncinate processes and facet joints were normal. There was no significant foraminal stenosis and no significant central canal stenosis. At C6-C7, there was mild to moderate foraminal narrowing due to uncinat process and facet joint arthropathy. There was a bulging annulus/osteophyte complex measuring 2 mm with mild ventral thecal sac contacts and residual AP diameter of the central canal which measured 9-10 mm. At C7-T1, there was no significant central canal or foraminal stenosis.

The employee was seen by Dr. on 08/08/06. The employee was reported to have low back pain and neck pain which was worse with flexion. The employee had no symptoms of spinal cord compression and no bowel or bladder incontinence. The employee did report occipital headaches and utilized Vicodin two to three tablets per day. On physical examination, he had slight hyperreflexia equal in the arms and legs, 3+ clonus bilaterally, with negative Babinski's signs. There was nearly full lumbar motion with most pain at flexion and nearly full cervical motion with most pain with flexion. An MRI of the lumbar spine indicated that the employee had disc desiccation and disc space narrowing and central herniation at L4-L5 and L5-S1. The employee was reported to have disc herniations at C4-C5 and C5-C6. A CT of the cervical spine was reviewed and did not reveal any evidence of severe deformity. Dr. Vaughan recommended against surgery on the lumbar spine and recommended additional evaluation of the cervical spine.

The employee underwent an Independent Medical Evaluation (IME) on 08/17/06 by Dr.. Dr. reported that the employee had received five to six months of physical therapy, and then

switched to chiropractic care. Dr. noted small protrusions involving the lumbar and cervical spines, and an MRI of the shoulder which indicated some degenerative tearing of the rotator cuff. On physical examination, the employee's grip strength was reported to be equal. Two point discrimination was intact. Upper extremity grip strength was rated as 5/5. Reflexes were all 2+ and symmetric. Right shoulder range of motion was reduced with minimal impingement. There was minimal tenderness in the low back. The employee was able to heel and toe walk without difficulty. Patellar reflexes were 1+. Achilles reflexes were 1+. There was no numbness or weakness of the leg. There was negative straight leg raising in both the sitting and supine positions. Dr. found the employee to have a cervical strain without radiculopathy and recommended against surgery for the neck or back. Dr. further noted that the employee had received excessive chiropractic care and recommended that the employee participate in a daily home exercise program. Dr. also indicated the employee was not a candidate for epidural steroid injections.

The employee was seen by Dr. on 09/12/06. Dr. opined after reviewing the employee's previous MRI that there was mild cord deformity from C4-C5 to C6-C7, and clinically the most painful area was now in the low back with disc protrusions at L3-L4, L4-L5, and L5-S1 on MRI. Dr. recommended a four level discogram.

A lumbar discography was performed on 01/03/07. L3-L4 was reported to be normal. L4-L5 was reported to show moderate disc space narrowing with diffuse fissuring of contrast into the superficial annular margin in all directions. At L5-S1, there was less pronounced disc narrowing with diffuse posterior and right lateral fissuring. There was moderate partial anterior fissuring with left lateral circumferential fissuring as well. The report of discography did not include any opening or closing pressures. L4-L5 was reported to be concordant to the middle low back. L5-S1 was reported to be severely concordant in the entire middle back and replicated the employee's usual pain. Dr. opined that the employee would be a good candidate for a two level interbody fusion using a 360 degree technique.

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

The available medical records indicate that the employee sustained a low speed motor vehicle accident. The employee has been seen by Dr. and serial examinations both as an RME and an IME found no conclusive data to establish that the employee's cervical and lumbar pathology are related to the motor vehicle accident. Dr. found that the employee had received extensive treatment. I would note that the employee has been under the care of Dr. who initially opined that the employee's cervical symptoms were far worse and recommended the performance of cervical surgery before lumbar surgery. That opinion subsequently changed rather quickly, and a recommendation was entertained for a two level fusion at L4-L5 and L5-S1 using a 360 degree technique. I have reviewed the employee's imaging reports and found no evidence of any documented cord signal change as alluded to in the record. I would further note that the records do not include a detailed preoperative psychological evaluation which would be imperative in this employee's case. Originally, it was felt that the cervical condition was significant enough to warrant surgery before any other and that subsequently changed rather rapidly with the low back being more significant than the cervical. This would be highly suggestive of some underlying psychobehavioral issues which should be explored prior to further consideration of an extensive 360 degree fusion procedure at two levels. The record further failed to substantiate that the employee had completed conservative care. Based on the current information, this request is not

considered medically necessary. The *Official Disability Guidelines* recommend “Preoperative clinical surgical indications for spinal fusion include all of the following: (1) All pain generators are identified and treated; (2) All physical medicine and manual therapy interventions are completed; (3) X-ray demonstrating spinal instability and/or MRI, myelogram, or CT discography demonstrating disc pathology; (4) Spine pathology limited to two levels’ (5) Psychosocial screen with confounding issues addressed; (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (*Colorado, 2001*) (*Blue Cross BlueShield, 2002*)”.

If the IMED’s decision is contrary to: (1) the DWC’s policies or guidelines adopted under Labor Code §413.011, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care or (2) the networks treatment guidelines,

IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- A. *The Official Disability Guidelines*, 11th Edition, The Work Loss Data Institute. Accessed: 02/02/07.
- B. *The American College of Occupational and Environmental Medicine Guidelines*, Chapter 12. Accessed: 02/02/07.
- C. S. Terry Canale, M.D., *Campbell’s Operative Orthopedics*, 10th Edition, University of Tennessee-Campbell Clinic, Memphis, TN, Le Bonheur Children’s Medical Center, Memphis, TN ISBN 0323012485.
- D. Barnbakidis N, Geiz-Drfan I, Klopfenstan J, Sonntag V. Indications for Surgical Fusion of the Cervical and Lumbar Motion Segment, *SPINE*, Volume 30, Number 16S, on S2-S6 ©2005, Lippincott Williams & Wilkins, Inc.