



IMED, INC.

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DATE OF REVIEW: 07/31/07

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Items in Dispute: Back surgery, bilateral lumbar decompression L4-5, L5-S1 with discectomy and posterior fusion with instrumentation.

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Radiographic report lumbar spine dated 03/21/07.
2. MRI of the lumbar spine dated 03/24/07.
3. Medical records Dr.
4. EMG/NCV study dated 04/10/07.

INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):

The employee is female who was reported to have sustained work related injuries on xx/xx/xx. The employee was going down stairs at her place of employment, when she missed the last two steps and stumbled but did not fall. It was reported that two weeks prior to this incident, the employee had also fallen down stairs at work landing sideways hitting her right knee. Following that particular event she was able to continue to work. Following the impact of

xx/xx/xx, the employee was reported to have developed severe low back pain that prevented her from returning to work.

The employee has a past medical history of surgery in 1985 and 1989, and most recently in 2001. By the employee's recollection, these were laminectomies and discectomies. The employee reported at the time of her fall that she had been free of back pain. The employee reported low back pain with radiation into the right lower extremity. She further reported weakness in the right lower extremity. The employee has been a diabetic for the past six years.

An MRI of the lumbar spine was performed on 03/24/07. This study reported levoscoliosis of the lumbar spine and a 4-5 mm anterolisthesis of L4 on L5 with bilateral facet arthrosis and a 3-4 mm subligamentous disc extrusion. At L5-S1, there was again reported bilateral facet arthrosis and a 4-5 mm anterolisthesis with disc desiccation, disc space narrowing, and a 3 mm subligamentous disc extrusion contacting the exiting nerve roots. The remainder of the spine appeared to be within normal limits with only thickening of the ligamentum flavum and a mild broad based bulge noted at L3-L4.

The employee was subsequently referred to Dr. on 03/31/07. At that time, the employee presented in a wheelchair secondary to pain. She was tender to deep palpation of the low back as well as to the left of midline. She was unable to flex or extend secondary to pain. Her straight leg raising test was negative. Neurologic testing showed weakness of the EHL and tibialis anterior on the right side. Dermatomal sensation was diminished over the right side over the dorsum of the foot extending into the medial and lateral aspects of the foot. Radiographs were noted as above. The employee was diagnosed with a lumbar disc herniation at L4-L5 and L5-S1 with a history of three prior disc herniations and possible lumbar instability at L4-L5. The employee was recommended to undergo electrodiagnostic studies.

The employee was referred for electrodiagnostic studies on 04/10/07. This study reported a severe chronic bilateral L5-S1 radiculopathy and a mild underlying polyneuropathy secondary to chronic diabetes.

The employee was seen in follow up on 04/14/07 and was referred for physical therapy.

When seen on 05/01/07, the employee was reported to be unable to tolerate it. The employee's physical examination was unchanged. Dr. requested to perform a redo discectomy at L4-L5 and L5-S1 and advised the performance of a fusion of these segments.

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 has a significant history of low back pain and has undergone operative intervention for multilevel disc herniations. The records suggest that at this point in time the employee has undergone at least three decompressions for these abnormalities. The employee's reported mechanism of injury is not consistent with the development of an acute disc herniation. The available medical records indicate that the employee has undergone a brief trial of conservative care which consisted of a few weeks of physical therapy which was stopped secondary to the employee's report of pain. The employee ambulates with the use of a wheelchair, which suggests disability behaviors. Electrodiagnostic studies show that the employee has a chronic L5-S1 radiculopathy, which clearly predates the compensable event. This condition is most likely secondary to the employee's previous operative intervention, and it would be presumed that her lower extremity weakness is chronic also. Given the presence of a radiculopathy, there was no indication that epidural steroid injections were attempted to return this employee to baseline. I would further note that current evidence-based guidelines require that a preoperative psychiatric evaluation be performed. One was not included in the available records for review. Given this information, the request for a two level fusion at L4-5 and L5-S1 is not considered medically necessary.

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.
- B. The *American College of Occupational and Environmental Medicine Guidelines*.
Chapter 12.