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Notice of Independent Review Decision

DATE OF REVIEW: 11/30/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Posterior spinal fusion L5-S1, ICBG pedicle screws and rods, anterior spinal fusion L5-S1, synthes, CCALIF, AOL screws, LSO bone growth stimulator, cryo unit x 10 day rental with 2 day inpatient stay.

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

Texas License
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. MRI of the lumbar spine dated xx/xx/xx.
2. Radiographic report left ribs dated 04/06/06.
3. Procedure report medial branch blocks dated 06/13/06.
4. MRI of the cervical spine dated 07/21/06,
5. CT of the brain dated 07/21/06.
6. Orthopedic evaluation dated 07/26/06.
7. EMG/NCV study dated 09/18/06.
8. Report of discography dated 10/18/06.
9. Post discogram CT of the lumbar spine dated 10/25/06.
10. Medical records Dr.
11. MRA of the brain dated 01/10/07.
12. Left sacroiliac joint procedure report dated 02/26/07.
13. Left sacroiliac joint procedure report dated 04/17/07.
14. Evaluation, D.C. dated 07/23/07.

15. Preauthorization request dated 10/31/07.
16. Preauthorization request dated 11/09/07.
17. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY)

The employee is a male who was reported to have sustained multiple injuries as a result of a fall of approximately twenty feet and landing on top of some metal equipment. The employee was reported to have injured the left side of his ribs, the neck, and the low back.

The employee was taken by ground ambulance to Hospital with a neck brace and back board. The employee had x-rays of his neck, low back and ribs. No fractures were identified. He was released the same day and recommended to have follow-up care.

The employee was reportedly seen at the Hospital due to severe pain in the left ribs and difficulty in breathing.

The employee subsequently came under the care of, D.C. who referred the employee for imaging studies.

The employee was later referred to Dr. for interventional procedures.

The submitted medical records indicate that the employee underwent an MRI of the lumbar spine on xx/xx/xx. This study reported a central disc bulge present creating mild flattening of the thecal sac centrally without significant stenosis or nerve root impingement. The employee was referred for radiographs of the ribs on this date, which were reported as unremarkable.

On 06/13/06, the employee underwent medial branch blocks performed by Dr.

The employee was subsequently referred for MRI of the cervical spine on 07/21/06, which was reported to be normal. There was noted to be a relative loss of normal cervical lordotic curve.

A CT of the brain without contrast was performed on 07/21/06, which was reported to be normal.

The employee was seen for an orthopedic examination by Dr., who noted that the employee had a herniated nucleus pulposus protrusion at L4-L5 and a cervical spine strain. Dr. recommended additional imaging studies, electrodiagnostic studies, and epidural steroid injections.

The employee was referred for EMG/NCV studies on 09/18/06, which were reported to be normal.

The employee was subsequently referred for lumbar discography on 10/18/06. This was a three level discogram performed at L3-L4, L4-L5 and L5-S1. The report of discography indicated that the employee had a normal disc at L3-L4 and L4-L5. There were no reports of low back pain. Opening pressures were 23 and 24 PSI with peak pressure of 70 and 72 respectively. At L5-S1, there was abnormal fissure disc morphology without contrast extravasation. The employee reported concordant low back pain with a VAS of 5-6/10. The opening pressure was 20 PSI with a peak pressure of 52. Dr. opined that the employee had concordant pain in the low back and right buttocks. The post CT scan reported that the appearance of the discs were essentially unremarkable, that there was no extravasation of contrast from the disc space into the spinal canal. There was generalized disc bulging noted posteriorly at L5-S1 without definite occlusion of the neural foramen or extrinsic pressure on the nerve roots at the L5-S1 level. The L4-L5 interspace demonstrated a small central disc bulge without neural foraminal stenosis.

The employee was seen by Dr. on 11/14/06. Dr. noted the history above and indicated that the employee had undergone physical therapy. He noted that the employee had undergone two facet blocks which gave him reasonable relief for one week. Upon physical examination, the employee had a normal gait. He was tender over the sacroiliac joint on the left side. Pain was easily reproduced by palpation over this site. Forward flexion and extension were reported to be uncomfortable, with more discomfort with extension. Straight leg raising was negative. He had no nerve root tension signs. Faber's test was negative bilaterally. Neurologic examination revealed all lower extremity myotomes and normal dermatomal sensation in all lower extremities. The employee underwent lumbar radiographs including flexion/extension studies. There was no spondylolisthesis or spondylolysis noted. There was no abnormal translation or rotation seen between flexion and extension. Dr. opined that the employee had a left sacroiliac joint sprain.

The employee was referred for MRA of the brain on 01/10/07, which was reported to be normal.

The employee subsequently underwent two left sacroiliac joint injections on 02/26/07 and 04/17/07.

The employee was seen in follow-up by Dr. on 04/24/07.

The employee was then referred to, M.D., on 05/14/07. Dr. opined that the employee would be an acceptable candidate for an artificial disc replacement, and secondary to that, a fusion procedure at L5-S1.

The employee was seen in follow up by Dr. on 06/05/07, who noted the employee should undergo operative intervention.

A note dated 10/27/07 indicated that the artificial disc replacement was denied at the IRO level. It has subsequently been recommended that the employee

undergo fusion at L5-S1 using pedicle screws at L5-S1 and an associated interbody technique.

This request was reviewed by Dr. on 10/31/07. Dr. recommended against the procedure. He noted that there was no documentation of a psychological clearance removing confounding issues that need to be addressed.

A second review was performed on 11/09/07. The reviewing physician, Dr., noted that the employee was being considered a spinal fusion candidate secondary to discography. He reported that the employee had previously been refused a disc replacement surgery at IRO level. He opined that based on the information provided, the was a poor fusion candidate as well. He noted that the discography report did not offer volume or pressure data and that discography in and of itself is a poor prognosticator of fusion surgery.

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

I would agree with the previous reviewers that the request for lumbar spinal fusion at L5-S1 with associated procedures and durable medical equipment is not medically necessary. The available medical records indicate that the employee sustained multiple injuries as a result of a fall from a relatively high height. The employee has been treated with oral medications, physical therapy, and medial branch blocks. The employee continues to report chronic low back pain. Imaging studies performed on 04/06/06 note disc abnormality at L4-L5 and reports a 2 mm disc bulge creating mild flattening of the thecal sac without significant stenosis or nerve root compromise. The L5-S1 level was reported to be unremarkable without evidence of disc herniations or stenosis. The employee has a normal EMG/NCV study with no evidence of a lumbar radiculopathy.

I would note that the employee's report of discography suggests that the employee has concordant low back pain rated as 5-6/10. The employee's opening pressure was similar to the other two discs tested and the peak pressure was reported to be 52 PSI. It is unclear from this report if concordancy was established with pain levels only reporting to be 5 or 6 of 10. Because of the employee's chronic complaints additional diagnostic studies were performed. The employee was initially opined by Dr. to have a left sacroiliac joint arthropathy and was referred for sacroiliac joint injections. The record does not include any preoperative psychiatric evaluation and noting the diffuseness of the employee's complaints this preoperative evaluation is certainly warranted and under current evidence based guidelines is required.

Given this lack of information, I would concur with the previous reviewers. It would be my opinion that the employee is a marginal candidate for a fusion procedure.

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

References:

1. ***Official Disability Guidelines***, Return To Work Guidelines (2007 *Official Disability Guidelines*, 12th Edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp*, 5th Edition) Accessed Online