



## **IMED, INC.**

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 11/29/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

L2-L5 Laminectomy decompression and fusion

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

Texas License  
Board Certified Neurosurgeon

**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. IRO referral form.
2. MRI of the lumbar spine.
3. xx/xx/xx - Neurological evaluation.
4. 03/27/07 - CT/post discogram.
5. 04/17/07 - Follow-up office visit.
6. 07/31/07 - Orthopedic evaluation.
7. 08/21/07 - Initial utilization review.
8. 10/04/07 - Designated Doctor Evaluation.
9. 10/28/07 - UR determination.
10. 11/06/07 - Appeal determination.
11. 11/06/07 - Chart note from Dr.
12. ***Official Disability Guidelines***

**PATIENT CLINICAL HISTORY (SUMMARY)**

The employee is a male who was reported to have sustained an injury to his lumbar spine on xx/xx/xx. The employee is currently under the care of Dr. The request is for L2-L5 lumbar laminectomy, decompression and fusion. The available medical records indicate that the employee was pushing a dolly up a ramp when a cart shifted resulting in a hyperextension injury to his back and the development of low back pain.

The employee was referred for MRI of the lumbar spine on 03/31/06. This study reported a left paracentral disc protrusion at L2-L3 without specific L2 nerve root compromise. At L3 there was a central disc protrusion at L3-L4 without specific L3 nerve root compression on the left or right. At L4 there was a tiny central disc bulge with a small protrusion at L4-L5 without associated nerve root compression. At L5 there was a mild bulging of the L5-S1 disc without focal protrusion. The study reported that the bony canal and neural foramina were widely patent at these levels.

The employee came under the care of Dr. on xx/xx/xx. Dr. noted the above history. Upon physical examination, the employee had an antalgic gait, normal coordination. Straight leg raising produced low back and bilateral posterior thigh pain at 45 degrees. Motor testing was intact. There was hypoalgesia to pinprick over the dorsolateral aspect of both feet. Otherwise, sensory testing was intact. Deep tendon reflexes were symmetrically hypoactive in the extremities. No pathological reflexes were identified. Lumbar flexion and extension x-rays revealed multiple levels of mild spondylosis. The employee was reported to have progressively severe mechanical low back pain with lumbar radiculopathy secondary to multilevel disc abnormalities.

The employee was referred for lumbar discography on 03/27/07. This study reported that the employee had concordant pain at L2-L3, which was reported to be 10/10 with contrast medium extending into the anterior epidural space consistent with a full thickness Grade 5 tear. Pressures were not identified. At L4-L5, the employee was reported to have concordant pain. Contrast medium was seen compatible with concentric tears. Pressure was not identified. The L3-L4 and the L5-S1 discs were reported to be normal. Post discogram CT reported a central accumulation of discographic contrast in the left lateral annular tear and a subannular accumulation throughout the majority of the annulus. There was a Grade 4 annular tear. There was diffuse bulge indenting the ventral thecal sac combining with facet and ligamentous hypertrophy to cause moderate stenosis of the spinal canal and mild to moderate bilateral neural foraminal stenosis. At L4-L5, there was no significant accumulation within the disc nucleus. Contrast was noted in the annulus primarily anteriorly with spreading along the annulus. This appeared to be due to an annular injection. There was a mild bulging of the annulus combining with hypertrophy of the ligamentum flavum, congenital canal stenosis causing moderate stenosis of the spinal canal.

The employee was subsequently referred to Dr. for second opinion. The letterhead of Dr. indicated both Dr. and Dr. were with, P.A. His recommendation

included surgical intervention at L2-L5. Records indicate the injured employee was a smoker.

The employee was seen by a designated doctor, M.D., on 10/04/07. At that time, Dr. opined that the employee was at clinical Maximum Medical Improvement (MMI) with a 5% impairment. Dr. notes indicated that the employee underwent an EMG/NCV study on 10/02/06 and noted that the employee had a chronic bilateral L5 and S1 radiculopathy. Dr. noted that the employee was unable to heel/toe walk. It was noted that the employee had reduced lumbar range of motion secondary to reports of pain. Dr. noted no loss of sensation in any of the dermatomes. and pulses and reflexes were within normal limits. There was good motor strength testing, and therefore, Dr. opined that the employee had low back pain with no evidence of radiculopathy resulting in a 5% whole person impairment.

The records include a clinical note dated 11/06/07. Dr. indicated he spoke with Dr. and reviewed the employee's case. Dr. apparently recommended a psychological evaluation of the employee preoperatively. Dr. opined that was unnecessary unless there were significant psychiatric problems in the employee's past. The request for operative intervention had been previously denied on 10/28/07 by Dr. Dr. noted the lack of a current examination, flexion and extension radiographs, and no current psychiatric evaluation as grounds for denial.

A second denial was reported on 11/08/07. Dr conducted a peer-to- peer with Dr. and discussed the lack of a required psychological evaluation. Dr. apparently felt a preoperative evaluation was not necessary.

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

I agree with the previous reviewers that the request for lumbar laminectomy, decompression, and fusion from L2-L5 is not medically necessary. As such, the denial is upheld. The available medical records indicate that the employee has chronic low back pain that is reported to be refractory to care. The available medical records do not indicate that the employee has undergone any interventional procedures. The records do note that the employee has undergone physical therapy and was treated with oral medications; however, the amount of physical therapy was not included within the available record. The employee has undergone lumbar flexion and extension radiographs, which revealed evidence of multilevel degenerative disease but no instability. The employee's imaging studies indicate minimal disease at L1-L2, L3-L4, and L5-S1 with abnormal discs and concordant pain at L2-L3 and L4-L5.

In my opinion, the request to fuse from L2-L5 despite these relatively unaffected disc spaces is not medically necessary or warranted. I would further note that

current evidence-based guidelines, ***Official Disability Guidelines***, require that the employee undergo a preoperative psychiatric evaluation regardless of the treating provider's opinion.

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

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