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DATE OF REVIEW: 01/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 and L5-S1 decompression with fusion. L4, L5, LS with pedicle screws and rods.

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

Board Certified in Ortho-Spine, Practicing 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. CT of lumbar spine
3. Medical Records, Dr. dated 12/06/06 thru 08/03/07
4. Medical Records, Dr. dated 05/04/07 thru 09/06/07
5. Procedure report, lumbar discography dated 06/15/07
6. Designated Doctor Evaluation dated 08/21/07
7. MRI of lumbar spine dated 09/01/07
8. Lumbar radiographic report flexion and extension views dated 09/01/07
9. Radiographic report lumbar spine dated 09/06/07
10. Utilization review determination dated 09/20/07
11. Designated Doctor Evaluation dated 10/17/07
12. Utilization review determination dated 11/21/07
13. MRI of lumbar spine dated 12/07/06.
14. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a female who was reported to have injured her low back and right hip. She was sitting in a high rolling chair auditing a chart, and as she got up, the chair slipped causing her to fall landing on her buttocks and right hip. The employee reported feeling an object hit her in the low back. She reported the development in immediate pain and a burning sensation down her right leg and foot with a numb sensation in the great toe and second toe.

The employee was seen in the emergency room where x-rays were obtained. She was diagnosed with sciatica and was given a prescription for Vicodin and Flexeril. She later returned to the emergency room for a CT scan of the lumbar spine.

The employee was later seen by Dr. and subsequently underwent physical therapy.

The employee was also seen by a chiropractor.

The employee discontinued therapy after four or five sessions due to increased pain.

Since the fall, the employee was reported to have been bedridden due to severe pain.

The employee came under the care of Dr. on 12/06/06, who noted the above history. The employee reported back pain that was worse on the right and went down the back of the right thigh to the calf to the foot and toes. X-rays from Medical Center indicated diffuse degenerative changes most predominant at L4-L5 and L5-S1 with associated disc space narrowing and a Grade I spondylolisthesis without spondylosis. A CT scan performed on the same date indicated no evidence of acute fracture of the lumbar spine, a grade I spondylolisthesis at L4-L5 and L5-S1 without spondylolysis. There was severe central canal and foraminal stenosis at the L4-L5 level. There was mild central canal narrowing and moderate bilateral foraminal narrowing at L5-S1. Upon examination, the employee had tenderness over the lumbosacral spine and over the sacroiliac joint on the right. There was severe tenderness over the right sciatic notch. She did not twist well in either direction. Patellar reflexes were 2+ and equal. Achilles reflexes were absent. There was decreased sensation in the right lateral calf. There was some difference on the medial side and complete difference on the lateral side in the foot. Sitting root test was ok. The employee was reported to have undergone epidural steroid injections on 01/31/07, one in February of 2007 and a third on 03/20/07. These were reported to have not provided a significant amount of relief. The employee continued to complain of low back pain which radiated to both buttocks, mainly on the right side with radiation into the right lower extremity.

The employee underwent EMG/NCV on 06/14/07, which was reported to be normal.

The employee was subsequently referred to Dr. for surgical evaluation. On 06/15/07, the employee underwent lumbar discography which reported a normal nucleogram at L3-L4 with non-concordant provocation. At L4-L5 and L5-S1, there were abnormal nucleograms with anterior lateral tear at L4-L5 and an anterior tear at L5-S1. Both levels were reported to produce strongly concordant pain.

The employee was later seen by Dr., a designated doctor, on 08/21/07. Dr. opined that the employee was not a clinical Maximum Medical Improvement (MMI) and noted that the employee was currently being considered for a two level fusion. Dr. opined the employee was not going to improve without having surgery preformed.

The employee was referred for an MRI of the lumbar spine on 09/01/07. This study reported at L5-S1 there was pronounced bilateral facet arthrosis, mild left lateralizing spondylosis with a broad-based 5 mm chronic protrusion lateralizing to the left paracentral and foraminal regions. There was moderate left high grade foraminal stenosis with mass effect on the left L5 ganglion approximal emanating route. There was moderate left lateral recess encroachment. There was mild central stenosis and left foraminal annular fissuring present. At L4-L5, there was a 2-3 mm degenerative anterolisthesis of L4 relative to L5 with severe facet arthrosis and mild ligamentous hypertrophy bilaterally. A 3-4 mm concentric disc protrusion was present. There was mild to moderate central stenosis with mild lateral recess encroachment bilaterally at the level of the proximal L5 nerve routes. There was fairly mild up down foraminal stenosis without displacement of the emanating L4 nerve routes. Flexion and extension views indicated significant arthropathy of the facets at L4-L5 resulting in Grade I spondylolisthesis with mild disc space narrowing at L3-L4, L4-L5, and L5-S1 with arthropathy at the facets to a lesser degree at L3-L4 and L5-S1. There was no fracture or dislocation seen. There was no significant translation or subluxation during flexion extension.

The employee was seen by a designated doctor, Dr, on 10/17/07. Dr. reported that the employee had clinical evidence of radiculopathy particularly in the right leg despite the fact that the employee's EMG was completely within normal limits. He reported the employee was not at MMI and recommended that the employee be seen by a qualified spinal surgeon. Dr. reported that there was some minimal degree of symptom magnification and this may be a result of the protracted pain for a long period of pain which had increased in intensity. Based upon the above information, the employee will be a surgical candidate as recommended for a two level disc fusion. The request for two level fusion at L4-L5 and L5-S1 was submitted for utilization review.

An initial review was performed by Dr. on 09/20/07. Dr. opined that there was insufficient documentation of conservative treatment to date and noted that the employee has not undergone a preoperative psychiatric evaluation. Therefore, Dr. recommended against the requested fusion procedure.

A clinical note dated 10/02/07 indicated that the employee was recommended to undergo a laminectomy but not a fusion under utilization review, and that Dr. did not wish to perform surgery without doing the indicated fusion. The employee continued to experience significant low back pain and pain down the right lower extremity into the right calf. The employee ambulated with the use of a walker or wheelchair. Upon examination, the employee stood in a forward flex position, and it was difficult for her to come up to a straight position. Lateral bending rotation and further forward flexion was restricted. There was pain in the right sciatic notch to deep pressure. Sitting root test was positive on the right. Patellar reflexes were absent on the right. Achilles reflexes were both absent.

An appeal to the initial utilization review decision was submitted on 11/21/07. At that time, Dr. recommended against the two level fusion and noted that the employee had not undergone psychiatric evaluation as required by current evidence-based guidelines.

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 decompression and fusion at L4-L5 and L5-S1 is not supported by the submitted medical documentation. The available medical records indicate that the employee developed low back pain after a slip and fall landing on the buttocks and right hip on the date of injury.

The employee's initial imaging studies indicate the presence of a significant amount of degenerative disease two levels. The employee has undergone conservative care consisting of oral medications, physical therapy which was terminated secondary to pain, and has received three epidural steroid injections. The employee's imaging studies indicate a significant amount of posterior element disease which has not been eliminated as a potential source of the employee's back pain. There was no indication that the employee has undergone medial branch blocks. The employee has undergone lumbar discography. It was noted that the employee is reported to have concordant pain at L4-L5 and L5-S1 with abnormal nucelograms. The report of discography does not include opening and closing pressures and maximum pressures obtained.

The information contained in this report suggests that the employee has degenerative disc disease at two levels. The employee has been seen by two designated doctors, who both have indicated that the employee is most likely a surgical candidate. Dr. noted some evidence of symptom magnification during

the performance of his examination. Current evidence-based guidelines require that employee's undergo preoperative psychiatric clearance to address any confounding issues prior to the performance of a fusion procedure. The available medical records do not include this psychiatric evaluation, and therefore, given the fact that the posterior elements have not been eliminated as a potential cause for the employee's chronic back pain and that the employee has not undergone psychiatric evaluation, the recommendation for two level fusion is not supported.

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

1. The ***Official Disability Guidelines***, 11th edition, The Work Loss Data Institute.
2. The ***American College of Occupational and Environmental Medicine Guidelines***; Chapter 12.