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Notice of Independent Review Decision

DATE OF REVIEW: 07/28/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Transverse process fusion L4-L5, L5-S1, bone graft, bone allograft, bone marrow autograft in situ, bone marrow aspirate, 3-day inpatient stay.

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

Board Certified Orthopedic Spine Surgeon
Practicing Neurosurgeon

REVIEW OUTCOME

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

Denial Upheld

The requested operative intervention is not medically necessary.

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a xx year old female who was reported to have sustained an injury to her low back as a result of a workplace event occurring on xx/xx/xx. The employee was working at an store with job duties that included repetitive lifting cases of oil, antifreeze, brake drums and rotors, etc. The employee periodically experienced soreness to her low back on multiple occasions which would remit with rest. On the date of injury, the employee experienced severe onset of low back pain after feeling and hearing a pop while lifting a case of oil to shelf height.

The employee was subsequently referred for MRI of the lumbar spine which noted disc desiccation at L4-L5 with a 2 mm circumferential disc protrusion which effaced the thecal sac, and mild bilateral facet arthropathy was noted without neural foraminal or central canal stenosis. There were postoperative surgical changes at L5-S1 with double titanium intradiscal cages without evidence of instability. The employee was under the care of , D.C.

The employee was subsequently referred to Dr. on 02/22/08. Dr. noted the above history. He reported that the primary area of pain was in the low back with a VAS

ranging from 5 to 9 and 5 to 6 with oral medications. The employee reported pain in the bilateral buttocks right greater than left. She could tolerate thirty minutes of sitting, forty-five minutes of standing, and thirty minutes of walking. The employee was reported to have received chiropractic manipulation and passive modalities and passive therapies provided by , D.C. The employee reported no benefit for any period of time. At home, the employee walked with activities of daily living only. She does not perform a home exercise program. The employee's past medical history was positive for lumbar fusion at L5-S1 in December, 1999 performed by Dr. . She reported that surgery provided her 100% relief until her date of injury. She also reported significant benefit from her postoperative therapy regimen. She further reported an ACDF in the 1980s. The employee's current medications were prescribed by Dr. and consisted of Lortab, Flexeril, Lyrica, Phenergan. The employee had previously taken Soma and also took aspirin. An MRI of the lumbar spine dated 03/15/07 was reported. It was noted that flexion/extension sequences were unremarkable. Prior to the lumbar fusion in 1999, the employee had undergone epidural steroid injection in the form of a series of 3 x 2. She had not had any interventional blocks since the date of injury. She has previously undergone lumbar discography for her surgery in 1999. Radiographs performed at this visit revealed dual back cages in the interspace at L5-S1 which appeared to be fully incorporated, disc space narrowing at L4-L5 with evidence of facet hypertrophy, and some arthropathy at L4-L5. On physical examination, the employee was 5 feet 11 inches in height and weighed 222 pounds. She was hypertensive. In the standing position, the employee flexed to 40 degrees with a right list and significant discomfort, as well as difficulty regaining neutral posture. Lateral bending revealed decreased range of motion in both directions with paraspinal muscle guarding, most significantly on the right. Extension and rotation are very painful in both directions. The employee guarded heavily. Tenderness was exquisite in the bilateral paraspinal muscles, as well as along the midline. There were scars consistent with the surgical history. Deep tendon reflexes were intact at the knees and ankles. Straight leg raise was reported to be positive on the left with pain reproduction in the low back. Lasegue's test was negative. Motor strength was graded as 4/5 in the left EHL and 5/5 in the dorsi/evertors. Feet were warm to touch. Dermatomal pattern revealed no paresthesias. The employee was diagnosed with a lumbar syndrome, status post intact ALF at L5-S1 and spondylosis at L4-L5. The employee was recommended to undergo a diagnostic caudal epidural steroid injection. The employee was reported to lack motivation as she was not walking therapeutically at home, did not participate in a home exercise program, and continued to smoke. The employee will be referred back to , D.C., for post injection therapy. Dr. reported pending the employee's response lumbar discography was a consideration.

On 03/24/08, the employee underwent a caudal epidural steroid injection. Post procedurally, the employee was reported to have a 75% pain reduction for two days and subsequently returned to baseline. She was reported to have participated in two sessions of physical therapy since the injection and indicated she had only had ultrasound and no active or passive therapies. She continued to smoke. She attempted to quit for one day.

On 04/07/08, it was recommended that the employee undergo lumbar discography.

The employee was subsequently referred to , Ed.D. The employee was reported to be psychologically capable of going through discogram or invasive procedure and for surgical intervention if that was an option. However, Dr. reported that the employee was very vulnerable to becoming a chronic pain patient. Should the discogram not provide any medical options or if medical options were not going to be pursued or do

not provide the anticipated benefit, the employee would have a difficult time. At that point, he recommended an interdisciplinary functional restoration and pain management program.

Records suggest that lumbar discography was not approved by the carrier.

The employee was subsequently referred for MRI of the lumbar spine on 06/23/08. This study reported a small central disc protrusion of 2-3 mm at L4-L5. There was a mild indentation on the anterior thecal sac, but no significant canal stenosis or mild bilateral foraminal stenosis. At L5-S1, there was a disc prosthesis in place. There was no evidence of significant canal or foraminal stenosis. Following administration of gadolinium, there was no abnormal enhancement.

The employee was seen in follow-up on 06/23/08 and was reported to experience continued low back pain. Her MRI was reviewed. On physical examination, active range of motion was severely restricted. She flexed to 45 degrees without discomfort. Lateral bending revealed paraspinal spasms bilaterally, right greater than left. Extension and rotation was positive bilaterally left greater than right with pain across the low back on both maneuvers. Tenderness was mild on the left and mild over the SI joints bilaterally, left greater than right. There were well healed scars. Deep tendon reflexes were augmented at the knees and intact at the ankles. Straight leg raise and Lasegue's test were negative. Motor strength was graded as 5/5 in the hip flexors, EHL and dorsi/evertors. Feet were symmetric and warm to the touch. There was no sensory deficit. The employee was diagnosed with a painful mechanical and chemical condition at L4-L5 secondary to transitional deterioration above the intact L5-S1 interbody fusion. The employee was recommended to undergo TLIF/PLIF at L4-L5 with pedicle screw fixation L4 to S1 plus transverse process fusion.

On 06/27/08, the case was reviewed by Dr. non-certified the request for operative intervention. He reported that the requesting physician had failed to demonstrate the necessity for fusion surgery. He reported that the presence of instability had not been established. He reported that the employee did not meet **Official Disability Guidelines** criteria for instability and noted that L5-S1 had a stable fusion already in place.

On 07/08/08, a reconsideration was submitted to Dr. found operative intervention was not medically necessary. He reported that the employee had been treated conservatively and appeared to have a solid fusion at L5-S1. The employee had undergone epidural steroid injections and physical therapy. He reported repeat MRI shows foraminal stenosis at L4-L5 with mild disc disease. He reported that there was no documentation that the pain generators had been identified. There was no documented neurologic deficit or instability and no evidence that pain generators had been identified. He reported that the employee appeared to have ongoing complaints of pain and had failed conservative treatments; however, the rationale for the proposed surgery was not outlined. As a result, Dr. non-certifies the request.

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

I would concur with the two previous reviewers in that the requested operative intervention is not considered medically necessary at this time. The available medical records indicate that the employee is status post lumbar fusion at L5-S1 performed in 1999 and subsequently sustained a workplace injury on xx/xx/xx.

The employee has been treated conservatively with a caudal epidural steroid injection, chiropractic treatment, and physical therapy with no reported relief. The employee has undergone repeat imaging on 06/23/08. This study only indicated a small central disc protrusion of 2-3 mm at L4-L5 with a mild indentation on the anterior thecal sac and no significant central canal stenosis. There was some mild bilateral foraminal stenosis and the lumbar fusion at L5-S1 appeared to be intact. The employee's most recent physical examination was not suggestive of a progressive neurologic deficit. The employee was noted to have pain with extension and rotation bilaterally, left greater than right, with pain that was localized across the low back in both maneuvers. The records do not indicate that the employee has a motor strength loss, sensory loss, or loss of relevant reflexes. The records indicate that the employee does not have any instability at the level above the fusion. The employee has evidence of posterior element disease.

The records do not establish a clear pain generator, and there was no evidence of instability on imaging. Given this information the employee would not meet criteria for lumbar fusion as defined in the ***Official Disability Guidelines***.

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. Deyo RA, Nachemson A, Mirza SK, Spinal-fusion surgery - the case for restraint, N Engl J Med. 2004 Feb 12;350(7):722-6
3. Gibson JN, Waddell G. Surgery for degenerative lumbar spondylosis: updated Cochrane Review. *Spine*. 2005 Oct 15;30(20):2312-20.
4. Atlas SJ, Delitto A. Spinal Stenosis: Surgical versus Nonsurgical Treatment. *Clin Orthop Relat Res*. 2006 Feb;443:198-207.
5. Resnick DK, Choudhri TF, Dailey AT, Groff MW, Khoo L, Matz PG, Mummaneni P, Watters WC 3rd, Wang J, Walters BC, Hadley MN; American Association of Neurological Surgeons/Congress of Neurological Surgeons. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 7: intractable low-back pain without stenosis or spondylolisthesis. *J Neurosurg Spine*. 2005 Jun;2(6):670-2.