



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 03/24/08

**IRO CASE #:**

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

Item in dispute: Posterior and anterior spinal fusion, anterior discectomy, posterior iliac bone graft L4-5, L5-S1 levels

**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 determinations should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Operative report dated 11/16/99
2. Medical records Dr. dated 04/22/03 thru 10/23/03.
3. Report of lumbar discography dated 06/03/03
4. Peer review, Dr. dated 05/27/04
5. Medical records Dr. dated 01/13/05 thru 04/04/07.
6. Operative report dated 03/13/07
7. Medical records Dr. dated 03/05/07 thru 03/06/07.
8. Medical records Dr. dated 03/22/07 thru 05/07/07.
9. MRI of the lumbar spine dated 05/07/07
10. Procedure report dated 06/07/07
11. CT of the cervical spine dated 10/04/07
12. Psychiatric evaluation dated 11/06/07
13. Psychiatric evaluation dated 12/04/07

14. Report of lumbar discography dated 01/03/08
15. Utilization review determination dated 01/18/08
16. Utilization review determination dated 02/15/08
17. ***Official Disability Guidelines.***

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The employee is a xx year old male who is reported to have sustained an injury to his low back on xx/xx/xx. The employee was employed by the xxxxxxx. On the date of injury, he was helping bring down a very obese person on a stretcher. He had to lift the stretcher up overhead and developed severe low back pain.

The employee was initially seen in a local emergency room and treated conservatively. He underwent a trial of medications, lumbar facet injections, epidural steroid injections, physical therapy, and an MRI. The MRI revealed the L4 nerve root not to be compressed but with a bulging disc at L4-L5 with desiccation of the same level.

The employee subsequently was declared refractory to conservative care and was taken to surgery by Dr. on 11/16/99, who performed a lateral left L4 discectomy.

The employee had continued pain postoperatively and was under the care of Dr., who performed an IDET procedure at the L4-L5 level.

Records indicate that the employee underwent lumbar discography on 06/03/03, which reported normal disc at the L3-L4 level and abnormal disc at the L4-L5 level with an annular fissure and tear with reported concordant pain graded as 8/10 at L4-L5. At L5-S1, there was a fissure into the annulus with concordant pain graded as 8/10.

The employee continued under the care of Dr. and later came under the care of Dr. who provided pain management. Records indicate that the employee returned to work on significant doses of oral medications. His job position was less rigorous, and he continued to work.

The employee was reported to have subsequently developed an injury to the cervical spine and later underwent anterior cervical discectomy and fusion on 03/13/07. This was reported to have been the result of a fall from a fire truck in October, 2006. This procedure was performed by Dr..

The employee had continued low back pain and was subsequently referred for MRI of the lumbar spine on 05/07/07. This study reported a right posterolateral intraforaminal disc herniation at L5-S1 that minimally impinged upon the exiting right L5 nerve root. It further reported a left posterolateral intraforaminal disc herniation at L4-L5 that was in a position to compromise the exiting left L4 nerve root. The employee also had multilevel facet arthrosis.

The employee was subsequently released to his job full-time full duty on 08/27/07. He was reported to have a normal mood and normal gait. He used no assistive devices to ambulate. His upper extremity motor function was symmetric, and he had a well-healed cervical incision. Radiographic report indicated some slight lucency noted in the graft between his C5-C6 fusion, but instrumentation was in good position. There was no loosening of the hardware.

The employee was subsequently referred for CT of the cervical spine on 10/04/07. This study reported an anterior cervical discectomy and fusion at C5-C6 which had resulted in what appeared to be a nonunion or at least a lack of osseous union, and there was some associated moderate to marked right bony neural foraminal stenosis, moderate left C3-C4 neural foraminal stenosis, and severe right C7-T1 facet arthrosis.

The employee was subsequently referred for psychiatric evaluation on 12/04/07. This was performed pre-lumbar discography. This study was performed on 01/03/08. It reported normal disc at L3-L4. At L4-L5, there was reported to be concordant mid back pain graded as 4/10. The appearance of the disc was reported to be degenerated with a posterior central herniation. At L5-S1, the employee reported 6/10 concordant pain with a degenerate posterior central disc herniation.

A clinic note dated 01/14/08 indicated that the employee presented for follow-up after lumbar discography. He reported that the employee was tired of all pain medications he had been taking and wanted something to resolve the problem once and for all. On physical examination, the employee was alert and oriented time three. He had normal coordination. He had a normal mood. He had no acute changes from the previous physical examination. Dr. recommended a two level lumbar fusion.

On 01/18/08, a request for anterior posterior fusion with anterior discectomy and posterior iliac bone graft at L4-L5 and L5-S1 was submitted by Dr.. This was denied by the physician reviewer who opined there was no discussion of discography or imaging studies in the most recent note. He indicated the request did not meet **Official Disability Guidelines**. This appears to have been performed by Dr..

A second request was submitted on 02/15/08. The physician advisor opined that the requested service exceeded the **Official Disability Guidelines** level of care. The claimant had chronic low back pain and did not meet the **Official Disability Guidelines** criteria for fusion in workers compensation. He noted there was no stenosis or spondylolisthesis or multilevel disease. This was a denial on reconsideration, which again appeared to have been performed by Dr..

**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 initially sustained an injury to his low back as the result of attempting to lift an obese employee over his head. The employee has undergone extensive treatment for this condition, which has included a lumbar discectomy at L4-L5 performed in 1999 and later an IDET procedure which failed to provide the employee any sustained relief. Additional records indicate that the employee has undergone extensive conservative treatment which has included physical therapy, lumbar epidural steroid injections, facet injections, and is maintained on oral medications by a pain management specialist. The employee's functional levels while on medication were sufficiently high enough that he was capable of returning to work in a less demanding position. In the interval period, the employee has undergone an anterior cervical discectomy and fusion, which was reported to have developed a pseudoarthrosis. Records regarding the employee's social history indicate that the employee is a smoker. Additional information indicates that the employee has undergone discography twice, first in 2003 which was reported to have significantly high levels of concordant pain graded as 8/10. A more recent lumbar discogram performed on 01/03/08 noted much lower levels of pain, 4/10 at L4-L5 and 6/10 at L5-S1. The employee has undergone psychiatric evaluation and was noted to have mild scores on both the Beck Depression Inventory and Beck Anxiety Inventory. The submitted records do not include any flexion or extension views of the lumbar spine which would establish instability at these levels.

I would concur with the previous reviewers that the employee does not appear to be a suitable candidate for a two level lumbar fusion. The employee potentially continues to have a pseudoarthrosis in the cervical spine, which was not fully discussed in the available records. The employee has a history of smoking. In my opinion, he would be a poor surgical candidate with high risk of pseudoarthrosis at the requested two levels due to his continued use of tobacco products. I would further note that there seems to be some inconsistency in the reported pain levels on repeat discography, and the employee while reporting concordant pain has far less pain than his original discogram at these levels in 2003. The employee has a longstanding history of chronic unremitting low back pain despite an operative procedure and an IDET procedure, and it would be my opinion that the employee is unlikely to develop any significant or sustained relief with the performance of a fusion procedure.

**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. Low Back Complaints