



## **IMED, INC.**

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

---

### Notice of Independent Review Decision

**DATE OF REVIEW:** 05/12/08

**IRO CASE #:**

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

Item in dispute: Posterior lumbar interbody fusion at L3-L4

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

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. Medical records Dr. dated 03/02/05 thru 04/24/08
2. MRI of the lumbar spine dated 03/21/05 thru 03/20/08
3. EMG/NCV study dated 05/09/05
4. Operative report dated 08/29/05
5. Utilization review determination dated 03/31/08
6. Carrier case summary notes dated 04/01/08
7. Letter of appeal Dr. dated 04/10/08
8. Utilization review determination dated 04/22/08
9. ***Official Disability Guidelines.***

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The employee is a male who was reported to have sustained an injury to his low back. The employee was on a ten foot ladder, leaned over, lost his balance, and caught himself before he fell. The employee felt a sharp pain in his low back.

The employee was initially treated conservatively and later taken to surgery on 07/12/96 and underwent an anterior lumbar interbody fusion with back cages at L4-L5 and L5-S1. Postoperatively the employee had continued low back pain and was subsequently opined to have a pseudoarthrosis.

Records include electrodiagnostic studies performed on 05/09/05, which indicate a mild left S1 radiculopathy.

The employee was taken to surgery on 08/29/05 and underwent a posterior lumbar interbody fusion at L3-L4 and L4-L5.

The employee underwent an MRI of the lumbar spine on 06/06/06. This study reported extensive postsurgical changes consistent with discectomies at L4-L5 and L5-S1, bilateral laminectomies at L3 and L5 with posterior stabilization, and evidence of foraminal narrowing at L4-L5 and L5-S1 secondary to facet joint osteoarthropathy.

Records indicate that the employee subsequently underwent hardware removal on 08/23/06.

The employee was subsequently referred for repeat MRI with and without contrast. This study performed on 03/20/07 and indicated postoperative decompressive laminectomy changes at L3-L4 and interbody fusion cages at L4-L5 and L5-S1. There was minimal enhancing scar tissue posterior to the thecal sac at the L3-L4 level. There was degenerative disc disease with mild bulge of the L3-L4 disc.

On 02/22/08, the employee was seen by Dr. . Motor strength was reported to be 5/5. Sensory was intact. Range of motion was good. Straight leg raising was positive. Cram's and Lasegue's tests were positive. The employee was reported to have increasing pain in his legs.

The employee was seen in follow-up on 03/20/08. Dr. opines that the employee has an adjacent level syndrome at L3-4. He reports that the employee has a herniation with stenosis at the L3-4 level. He opines this is indirectly related to his old injury and recommends doing a PLIF at L3-4.

On 03/31/08, the case was reviewed by Dr. Dr. indicated an Independent Medical Evaluation (IME) report indicated that the employee required no further surgery, and that management of his medication should be performed by his family physician. Dr. noted that the request was not certified. The employee had a mild disc bulge at L3-L4 with minimal enhancing scar tissue posterior to the thecal sac at L3-L4. Dr. noted there were no clinical notes submitted for review,

and the employee had no definitive instability, and therefore, no indication for fusion above the level of the prior fusion.

On 04/10/08, Dr. submitted an appeal letter indicating that discectomy at the level adjacent to the previous fusion had almost 100% failure to relieve back pain and did result in subsequent operations. Dr. would prefer to do a fusion at the time of decompression. If this is not acceptable, he could plan on doing just simply decompression; however, he believed that performing decompression with fusion was in the best interest of the employee. A request had been submitted for reconsideration.

On 04/22/08, this case was reviewed by Dr. Dr. found that the requested interbody fusion was not supported by sufficient clinical information. He noted that in the postoperative period, the employee had continued reports of pain with electrodiagnostic evidence of mild S1 radiculopathy. He noted that the repeat imaging studies indicated a mild disc bulge at L3-L4 and opined that this did not constitute significant adjacent segmental disease. Dr. further noted that the employee was not documented as being refractory to all conservative care and indicated that the employee had not undergone a preoperative psychiatric clearance. Dr. further noted that the records did not include any flexion or extension radiographs to establish instability. Dr. recommended against certification.

**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. The requested posterior lumbar interbody fusion at L3-L4 is not supported by sufficient clinical information.

The available medical records indicate that the employee has undergone three operative interventions regarding his low back, the most recent being a hardware removal. In the postoperative period, the records indicate the employee had continued low back pain. He has recently undergone MRI and was found to have some very mild degenerative changes above the level of fusion. There are no supporting documents which establish that this level is unstable. The findings on imaging are mild. Further, Dr.'s notes do not indicate that the employee is refractory to conservative care. There was no documentation of physical therapy or interventional procedures being performed.

Given this lack of information, I would again concur with the two previous reviewers. There is insufficient information to establish medical necessity. Additionally current evidence-based guidelines require that a employee undergo a preoperative psychiatric clearance for lumbar fusion. Noting this employee's history of multiple procedures, this clearly could have an impact on the success or failure of any attempt at operative intervention. The records do not indicate

that the employee has been referred for presurgical psychiatric clearance as required.

**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.
3. Terry Canale, M.D., ***Campbell's Operative Orthopedics***, 10th Edition University of Tennessee-Campbell Clinic, Memphis TN, Le Bonheur Children's Medical Center, Memphis, TN ISBN 0323012485.