



## **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:** 05/20/08

**IRO CASE #:**

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

Item in dispute: Lumbar laminectomy, foraminotomy, osteophyctomy, medial facetectomy and discectomy at L2-L3, left and L3-L4 at level L4-L5, lumbar laminectomy, foraminotomy, osteophyctomy, facetectomy, discectomy, and fusion with instrumentation with pedicle screws and Techtronic plate.

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

Board Certified Neurosurgeon

### **REVIEW OUTCOME**

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

Denial Upheld

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

The employee was xx years old when he was reported to have been involved in a motor vehicle accident on xx/xx/xx. The employee was reported to have been driving down a freeway when he was struck and forced into a concrete wall.

The employee was initially evaluated at Medical Center on xx/xx/xx. On physical examination, there was no swelling. The employee had full range of motion of the cervical spine with pain on extension and flexion. The thoracic spine had no point tenderness and full range of motion with pain. Examination of the lumbar spine revealed negative straight leg raising, no ecchymosis, no erythema, no external trauma, normal gait, symmetric reflexes, with normal sensation. There was reported to be pain on flexion and extension. The remainder of the back examination was unremarkable. Radiographs performed on this date of the cervical, thoracic, and lumbar spines reported chronic changes. The employee

was diagnosed with a lumbar strain, thoracic strain, and cervical strain. He was provided oral medications and was taken off work.

The employee was subsequently seen in follow-up by Dr. on xx/xx/xx. The employee reported his pattern of symptoms was worsening. He had been compliant with his medications and had not improved. He reported being sore all over. His neck and back hurt. On examination of the cervical spine, there was tenderness in the right neck into the trapezius. His active range of motion was decreased to the left. Examination of the lumbar spine revealed normal sensation, symmetric reflexes, and negative bilateral straight leg raising. There was tenderness of the left thoracic spine at the level of T12-L1 across the right side at L5-S1 level. There appeared to be paresthesias in the left lower extremity. Radiographs were reviewed. His thoracic spine had osteophytic spurs and bridging noted to many levels. The cervical spine revealed a C5-C6 fusion. There was a loss of lordosis. There was narrowing at C6-C7. The employee was continued on oral medications and scheduled for physical therapy.

The employee was seen in follow-up on xx/xx/xx. At that time, he reported his pattern of symptoms were stable. He was not working. He had been taking his medications and was requesting a refill. He had physical therapy one time and felt better. On physical examination, the employee had decreased active range of motion in all directions with focal tenderness of the left and right neck into the trapezius, right greater than left. Examination of the lumbar spine revealed tenderness from T12 through S1 and decreased active range of motion. His neurologic examination was unremarkable. The employee was to continue with his previous physical therapy schedule.

The employee was seen in follow-up by Dr. on xx/xx/xx. At that time, he reported his pattern of symptoms was stable. He reported numbness in the left hip, thigh to the left knee, and the popliteal area, and left neck shoulder to hand paresthesias not dissipated. He had focal tenderness of the left and right neck into the trapezius left, greater than right. He had decreased active range of motion in all directions. Examination of the lumbar spine revealed normal sensation, symmetric reflexes, a negative Faber's test, and tenderness at L5-S1 and over the right SI joint. The employee was referred for an MRI.

On 11/27/07, the employee underwent an MRI of both the cervical and lumbar spines. The MRI of the cervical spine reported a 2-3 mm focal right paracentral protrusion at C4-C5 which minimally indented the spinal cord contours which resulted in no significant or minimally significant central canal stenosis. At C5-C6, there was a firm bony interspace operative fusion appearance. At C6-C7, there was a mild degree of central canal stenosis from a broad-based posterior central to right paracentral protrusion of osteophytic bone or disc substance. There was drying or desiccation involving all visualized interspace substance. An MRI of the lumbar spine was performed on the same date. This report indicated a 4-5 mm left foraminal discal substance protrusion at L2-L3. At L3-L4, there was a 3-4 mm left foraminal discal substance protrusion. At L4-L5, there

was a Grade I spondylolisthesis with bilateral pars defects and 4-5 mm of anterior displacement of L4 on L5. At L5-S1, there was a prominently reduced interspace width and small anterior and posterior marginal bony osteophytes. There was drying or desiccation involving all visualized interspace substance.

The employee was subsequently referred to Dr. on 12/20/07. Dr. noted the history above. The employee had complaints of headaches, neck pain radiating between his shoulder blades into his left deltoid with numbness in the left triceps and left hand, and low back pain radiating into the left leg to the back and his left knee. Activity intensified his discomfort. Driving caused bilateral arm pain. His lumbar pain was worse with bending or stooping. The employee's past surgical history was positive for lumbar laminectomy at the L5-S1 level in the 1980s, a cervical fusion in the 1980s, and facial reconstruction in the 1970s following a 30 foot fall. The employee was further noted to be a Type II diabetic and hypertensive. On physical examination, he was alert and oriented. His neck had suboccipital muscle spasms and scalene muscle spasms. There were rhomboid muscle spasms. Range of motion of the neck was decreased. Deep tendon reflexes at the biceps were 2+, triceps were 1+ on the left and 2+ on the right. Pinprick sensation was intact in the upper extremities with the exception of third finger of his left hand, and he reported that this had been decreased since he was in the military. On examination of his back, there was tenderness in the interspinous ligament at L4-L5. There was tenderness in the sacroiliac area, left greater than right. Right knee jerk was 2+. The left knee jerk was absent. Ankle jerks were trace bilaterally. There was a negative Babinski's and Hoffman's. There was no weakness in dorsiflexion or plantar flexion. Pinprick sensation was intact in the medial lateral aspect of the left foot and the medial lateral aspect of the right foot. Straight leg raising on the left was positive at 70 degrees with back and left hip pain. Straight leg raising on the right was positive at 80 degrees with back pain only. He could stand on his toes and heels. He had a healed midline scar in his lower back from a prior surgery. He had a healed scar in his neck from a prior surgery. Dr. recommended that the employee undergo anterior cervical discectomy and fusion at C4-C5 and C6-C7 and a lumbar laminectomy, foraminotomy, osteophylectomy, medial facetectomy and discectomy at L2-L3 on the left and L3-L4 on the left. At L4-L5, Dr. proposed a lumbar laminectomy, foraminotomy, osteophylectomy, facetectomy, discectomy, and fusion with insertion of a vertebral spacer.

A request for preauthorization was submitted on 01/28/08. The physician reviewer non-authorized the requested lumbar procedures. He reported that the proposed surgery at three levels with fusion at L4-L5 for apparent spondylolisthesis with disc excision at L2-L3 and L3-L4 on the left. He noted that the official MRI report was not consistent between the body of the report and the impression of the report. He further reported that a fusion placed next to an abnormal disc space would not provide any long-term benefit as there was known enhanced breakdown rate of the adjacent disc anyway. With an abnormal disc, the breakdown would be even faster. He reported that Dr. did not report any abnormal neurologic findings on his examination to correlate with L2-L3, L3-

L4, or L4-5 levels. The proposed procedure was not validated by these records as medically necessary.

The employee was seen by Dr. on 02/12/08. Dr. reported that he had not received a denial; however, the employee had. He indicated that the employee had more pain radiating down his posterior left leg and he now had soreness in his right leg. He was starting to experience numbness in his left leg now too. When he bent down, he had to catch his back. He was unable to work due to pain and discomfort. Dr. reported that it was the L4-L5 level that caused his back pain with spondylolisthesis, not the L2-L3 and L3-L4 levels. He reported that he understood there was added stress to the L3-L4 level with the fusion at the L4-L5 level. However, the employee was unable to get rid of his back pain or the spondylolisthesis without fusing that joint. Taking out the disc at the other levels would most likely increase his deficit with the spondylolisthesis.

A subsequent request for reconsideration was submitted on 02/18/08. This was again not certified; however, the reviewer's rationale was not readily identified in the paperwork.

A subsequent request was placed on 03/13/08. The reviewing physician indicated that this was a request for reconsideration. The reviewer recommended a partial authorization for foraminotomy, osteophyctomy, facetectomy, discectomy, and fusion with instrumentation with pedicle screws and Tektronix plate at L4-L5. He did not authorize the laminectomy, osteophyctomy, medial facetectomy, or discectomy at L2-L3 and L3-L4 on the left. He reported that the employee was injured in the cervical and lumbar spines on xx/xx/xx when involved in a motor vehicle accident. According to the notes, the employee has failed conservative care which includes physical therapy and medications. He has a previous history of lumbar laminectomy at the L5-S1 level in the 1980s. He is diabetic and hypertensive. The note from the neurosurgeon dated 02/12/08 stated the employee's instability and myelopathy has continued to progress, and paresthesias and sensory loss was worsening down his legs, worse on the left more than the right side. Physician contact was made with Dr.. He summarized his clinical history and said he was interested in performing the surgery at the L4-L5 level and no other level. It was mutually agreed that due to the progressive myelopathy and instability and the lumbar spine findings on MR imaging, it would be prudent to authorize the fusion surgery at the L4-L5 level at this time.

The employee was seen in follow-up on 03/24/08. Dr. indicated that his plan was to perform discectomy, osteophyctomy, medial facetectomy, and decompression of the nerve roots at the L4-L5 level with insertion of a vertebral spacer. He reported that the request for osteophyctomy, medial facetectomy, foraminotomy, and discectomy at the L2-L3 and L3-L4 levels on the left was not approved. He reported that the employee was symptomatic with a large herniation at L3-L4 on the left and L2-L3 on the left with displacement. He reported that the employee did not want to have a partial surgery. He

recommended just a discectomy at the L2-L3 and L3-L4 levels on the left side decompressing the nerve root with partial lumbar hemilaminectomy. He reported due to pars interarticularis defect and spondylolisthesis, an arthrodesis with spacer was necessary at the L4-L5 level.

The employee was seen for second opinion on 04/17/08. Dr. noted the employee's history and imaging studies. He reported that the employee had two issues going on. He had a C5 and C7 radiculopathy likely related to findings on his imaging studies. Dr. informed the employee that having failed conservative measures, the proposed surgery at C4-C5 and C6-C7 was a reasonable option. He reported that the employee had mechanical back pain and some sciatica related to the findings on his imaging studies. He had failed conservative measures. He had reviewed the diagnosis. He found that an L4-L5 laminectomy with interbody fusion and pedicle screw fixation with posterolateral fusion was certainly a reasonable option.

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

Based upon my review of the medical records and the utilization review outcomes, I would concur with the previous utilization review determinations that surgery as requested is not medically necessary. The records indicate that the employee sustained injuries to both the cervical and lumbar spines as a result of being involved in a motor vehicle accident on xx/xx/xx. Records indicate that the employee has undergone conservative care, which has consisted of oral medications, physical therapy, and has subsequently not improved based upon the medical records. The employee has undergone MRIs of both the cervical and lumbar spines with noted disc protrusions at L2-L3 and L3-L4 entering the left neural foramina. The employee was noted to have a Grade I spondylolisthesis and bilateral pars defect with anterior displacement of L4 on L5, and there was predominantly reduced interspace width and a small anterior and posterior marginal bony osteophyte. The employee's past medical history was positive for both previous cervical and lumbar surgeries. It was noted on the initial preauthorization request that the reviewing physician did not approve the requested procedures in part due to a lack of clinical information which was appropriate. Further clinical information was provided and the final reviewer appropriately noted that the employee had segmental instability and symptoms which corresponded to an L4-L5 herniation with instability. As a result, the reviewer recommended a partial approval for foraminotomy, osteophylectomy, facetecomy, and discectomy with fusion and instrumentation with pedicle screws and Techtronix plate at L4-L5. He did not authorize procedures at L2-L3 or L3-L4. The employee was subsequently referred for a second opinion to Dr. who supported this proposal and indicated that an L4-L5 laminectomy with interbody fusion and pedicle screw fixation with posterolateral fusion was certainly a reasonable option for this employee. The negotiated recommendations were not accepted. Current IRO regulations do not allow for partial approvals

in the final review of this case.

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