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DATE OF REVIEW: 11/10/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: XLIF L2-3, 3-4, Scolio post T10 - L4 w/5 day stay.

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 determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Medical records Dr. dated 12/13/06 thru 09/09/08
2. Medical records Dr. M.D., dated 07/10/08
3. Utilization review determination dated 09/29/08
4. Utilization review determination dated 10/15/08
5. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who is reported to have sustained an injury to his left ankle on xx/xx/xx when he was climbing onto a truck and fell off.

The employee subsequently underwent open reduction/internal fixation with plates and screws.

The employee was seen by Dr. on 12/13/06. He reports that he also injured his back and had complaints of constant back pain ever since. He had intermittent radicular symptoms that would go down either leg or sometimes both. He was reported not to have performed any specific back physical therapy and appeared to have undergone epidural steroid injections which did not help. Upon physical examination, the employee

was noted to be 5 feet 11 inches in height and weighed 157 pounds. He was in no acute distress. He had an antalgic gait favoring the left leg. He had obvious scoliosis in the lumbar spine with a rightward apex and then significant lean toward the left where there was a leftward apex in the thoracic spine. This caused the shoulders to be significantly displaced to the left in relation to his pelvis. Otherwise, there were no significant skin changes. The employee did have tenderness along the right lateral spine and some hypertonicity in the paraspinal muscles. There was stiffness in all general planes of motion. Most of his pain was aggravated with extension and flexion. Lower extremity strength was intact. Muscle tone and mass was normal. Joint range of motion was within functional limits with the exception of the left ankle where the employee continued to have some post surgical stiffness. Sensation was grossly normal throughout the lumbar dermatomes. Reflexes were symmetrically diminished. Radiographs taken at this visit revealed severe degenerative scoliotic changes with a rightward apex in the lumbar spine centered about L3. There was some rightward listhesis of L3 on L4. There was leftward listhesis of L1 on L2 where there was bridging lateral osteophytes both sides and significant sclerosis at the disc level suggesting auto fusion at that level. This was where his leftward tilt was initiated and began to curve upwards into the thoracic spine. The remainder of the pedicles and spinous process were unremarkable. The employee had significant sclerosis throughout the lumbar spine. The sacroiliac joints were patent. The hip joints had some mild degenerative changes but were otherwise unremarkable. On lateral film, the employee had a Grade I retrolisthesis of L3 on L4 that appeared to worsen slightly in extension when compared to flexion. There was severe disc height loss, vacuum disc phenomena at L2-L3. L4-L5 was not seen head on but appeared to have mild degenerative changes. Again sclerosis was noted throughout the posterior elements and significant facet hypertrophy at the L3-L4 level. The employee was diagnosed with chronic low back pain with intermittent radiculopathy, severe degenerative lumbar scoliosis, and a hypermobile segment at L3-L4.

The employee followed up with Dr. on 09/13/07. The employee was now reported to be involved in DARS and undergoing retraining.

On 09/09/08, the employee was seen in follow-up by Dr.. He reported it had been several years since he had seen the employee. The employee reported that he had undergone pain management with Dr. and had seen Dr. on several occasions. It was reported that the employee was attempting to receive treatment through the DARS program. The employee had been advised that they would need a formal rejection by workers' compensation, and he was here that day to essentially get this requested and either done through work comp or pursue it through DARS. The employee's physical examination was unremarkable. He was well-developed and well-nourished. He was in no acute distress. He had appropriate mood and affect. He had a normal gait pattern. He was independent with mobility. He had some discomfort with position changes. Dr. notes indicate increasing thoracic curve measuring 40 degrees L1 to L5 and a 40 degree compensatory curve T3 to L1. The employee was reported to have a prior consolidation at L1-L2, which was reported to be consistent with

an older injury. Dr. review of films dated 02/07/07 reported 15 degrees of focal scoliosis at L2-L3, 10 degrees at L3-L4, and auto fusion at L1-L2 with 30 degrees of focal kyphosis. A request was subsequently placed for XLIF L2-L3 and L3-L4 with scoli post T10-L4 with five day inpatient stay.

On 09/29/08, this case was reviewed by a physician advisor, Dr.. Dr. utilized an **Official Disability Guidelines** citation indicating lumbar fusion for Scheuermann's kyphosis, noting that the employee had less than 70 degrees of thoracic kyphosis. He subsequently non-certified the request.

The case was sent to appeal on 10/15/08 and appeared to have been reviewed by Dr.. Dr. again non-certified this request. His notes suggest a Required Medical Evaluation (RME) may be required.

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 employee does not meet criteria for fusion secondary to Scheuermann's kyphosis by the **Official Disability Guidelines**. I would further note that the employee's scoliosis was clearly very advanced at the time of his alleged event, and in my opinion, this condition would not have been the result of his slip and fall.

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.

Lumbar fusion for Scheuermann's kyphosis: Recommended as an option for adult patients with severe deformities (e.g. more than 70 degrees for thoracic kyphosis), neurological symptoms exist, and pain cannot be adequately resolved non-operatively (e.g. physical therapy, back exercises). Good outcomes have been found in a relatively large series of patients undergoing either combined anterior-posterior or posterior only fusion for Scheuermann's kyphosis. ([Lonner, 2007](#))