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

DATE OF REVIEW: 06/22/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Lumbar Spine Fusion, apply spine prosthetic device, bone marrow aspiration, removal of bone for graft lumbar spine fusion, removal of spinal lamina, remove spinal lamina add, insert spine fixation device, removal of bone for graft intra op nerve test

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

Texas Board Certified Neurosurgeon

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. Lumbar spine 5 views 06/12/07
2. Lumbar spine MRI 08/06/07
3. Consultation report 08/13/07
4. Electrodiagnostic testing 08/16/07
5. History and physical 10/10/08 Dr.
6. Follow-up low-up note 10/27/08 Dr.
7. Office visit note 11/07/08 Dr.
8. Office visit note 12/12/08 Dr.
9. Office visit note Dr. 01/09/09
10. Operative report 01/29/09 lumbar epidural steroid injection
11. Psychological reevaluation 02/05/09
12. Office visit Dr. 02/13/09
13. MRI lumbar spine 02/27/09
14. Lumbar spine 9 views 03/11/09
15. Follow-up note Dr. 03/20/09
16. Utilization review determination dated 04/09/09
17. Utilization review determination dated 04/28/09

18. IRO documentation letter 06/10/09 Dr.
19. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The medical records indicate the employee lifted a heavy package of charcoal with the acute onset of low back pain.

An MRI of the lumbar spine dated 08/05/07 reported disc degeneration at L5-S1 with spondylolisthesis and degenerative type changes with shallow protrusion and annular tear with extruded fragment or nerve root displacement. The remaining lumbar levels were negative for disc herniation or stenosis.

A repeat MRI of the lumbar spine dated 02/27/09 reported degenerative disc disease involving the L5-S1 disc space, with re-demonstration of central and right sided disc protrusion due to annular tear on the right side at L5-S1 with obliteration of epidural fat and slight impingement on the right S1 nerve root. There was no evidence of central spinal canal, lateral recess, or foraminal stenosis. There was no evidence of spondylolisthesis or spondylolysis. Electrodiagnostic testing reported findings suggestive of acute right L5-S1 root irritation. The employee was treated conservatively with physical therapy and epidural steroid injections without significant improvement.

A neurologic examination by Dr. performed on 03/30/09 reported lumbar range of motion was decreased in forward flexion secondary to pain. Motor examination revealed 4/5 strength in gastrocnemius muscle on right, otherwise 5/5 throughout. Deep tendon reflexes were 2+ throughout and symmetrical. Plantar responses were flexor bilaterally. Gait was antalgic. The employee had difficulty with toe walking, less difficulty with heel walking, and no difficulty with tandem walking. Straight leg raise was positive on the right at 50 degrees and negative on the left. Sensory examination revealed a hypoesthetic region in S1 distribution on the right to pinprick and light touch, otherwise intact. Coordination was intact. Dr. recommended that the employee undergo anterior lumbar interbody fusion at L5-S1, posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L5-S1.

A utilization review determination dated 04/09/09 determined the request was not the most reasonable choice of procedures, noting there was no lumbar instability reported.

A reconsideration request was reviewed, and determination on 04/28/09 recommended non-certification, noting there remained no clear documentation of diagnosis/condition for which fusion was indicated such as instability.

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

I am in agreement with the two previous reviewers that medical necessity is not established for anterior lumbar interbody fusion at L5-S1, posterior lumbar decompression, posterolateral fusion with pedicle screw instrumentation at L5-S1.

The employee has evidence of degenerative disc disease at L5-S1 with annular tear and nerve root impingement on the right S1 nerve root. There was no evidence of central canal stenosis, lateral recess stenosis or foraminal stenosis. There was no evidence of instability of the lumbar spine. Lumbar spine x-rays performed on 03/11/09 reported no abnormal alignment and no abnormal motion between flexion and extension.

The records presented do not support a change in determination, and the previous denial is affirmed.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines***, Return To Work Guidelines (2009 *Official Disability Guidelines,* 14th Edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp,* 7th Edition) Accessed Online