



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
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: 10/15/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Two day Inpatient stay; L4-L5 L5-S1 Anterior Posterior Fusion

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.

PATIENT CLINICAL HISTORY (SUMMARY):

This employee was injured on xx/xx/xx while performing her usual job lifting boxes from a conveyor belt. She began having low back pain without radiation.

The injured employee had initial physical therapy and was found at Maximum Medical Improvement (MMI) on 11/19/08 with an impairment of 5%. This was from Lumbosacral DRE Category II impairment. She was also treated for osteonecrosis.

MRI of the lumbar spine was performed on 01/24/09, which revealed degenerative disc desiccation at L4-L5 and L5-S1 with a small right foraminal disc protrusion at L4-L5.

Dr. examined the employee, found her to be neurologically intact, and had recommended an anterior/posterior arthrodesis at L4-L5 and L5-S1.

The employee had received facet joint injection with temporary relief.

A psychological evaluation was performed, which found her to be stable.

A discogram on 08/20/09 found a normal disc at L3-L4, a mildly degenerative disc at L4-L5, concordant low back pain and normal resistance, and a mildly degenerative disc at L5-S1 with reduced resistance and concordant low back pain.

Official Disability Guidelines discuss criteria for performing lumbar fusion, as well as the advisability. Lumbar fusion was recommended as a treatment for carefully selected employees after an appropriate period of conservative care. This NAS test recommendation was based on one study that contained numerous flaws. At the time of the xxxx year follow-up, it appeared the pain had significantly increased in the surgical group in year 1-2.

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

The most significant deficiency in this recommendation was that there were no diagnostic studies that presented any instability. **Official Disability Guidelines** recommendation also contained criteria for performing the surgery that included demonstration of instability. This could be either due to postoperative changes or degenerative changes. This employee had no such studies. She had mild degenerative changes in her MRI and minimal changes on the discogram. Therefore, this request is not certified. This claimant was neurologically intact and had no indications for an arthrodesis of any kind.

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

1. Official Disability Guidelines