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Notice of Independent Review Decision

DATE OF REVIEW: 12/23/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Laminectomy with placement of interspinous spacer at L2-3, L3-4 with 1-2 day stay.

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

Texas 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. Chiropractor progress notes of xxxxx dated 10/31/03, 11/03/03, 10/05/03, 11/10/03, 11/12/03
2. Initial examination report Dr. D.C. 12/02/03
3. MRI lumbar spine with and without contrast xxxxxx 01/22/04
4. Pain management consultation Dr. 01/06/04
5. Follow-up note Dr. 02/03/04
6. Report of medical evaluation Dr., D.C. 01/10/04
7. CT of the lumbar spine with contrast post-discography 11/06/08
8. Procedure note Dr. 07/09/04
9. MRI of the cervical spine without contrast Doctor's Imaging Center 07/04
10. MRI of the lumbar spine without contrast Doctor's Imaging Center 12/07/04
11. Procedure note Dr. 03/11/04
12. Insurance claim dated 03/25/04
13. Follow-up note Dr. 03/18/04
14. Follow-up note Dr. 03/24/04
15. Neurological consultation 04/15/05
16. Procedure note Dr. 04/30/04
17. MRI of the cervical spine without contrast xxxxxx 05/06/04

18. Follow-up note Dr. 05/25/04
19. Procedure note Dr. 08/24/04
20. Neurological surgery independent medical evaluation Dr. 8/13/04
21. Follow-up note Dr. 09/07/04
22. New patient evaluation Dr. 10/19/04
23. MRI of the cervical spine without contrast Doctor's Imaging Center 12/07/04
24. MRI of the lumbar spine without contrast Doctor's Imaging Center 12/07/04
25. Follow-up evaluation Dr. 12/14/06
26. Designated doctor evaluation Dr. 02/04/05
27. Requested medical examination Dr. 04/15/05
28. Order for home health consult Dr. 03/13/06
29. Operative report Dr. 03/13/06
30. Follow-up evaluation Dr. 01/20/06
31. Chest x-ray MHH 02/28/06
32. Follow-up evaluation Dr. 03/07/06
33. Consultation note Dr. 03/06/06
34. Echocardiogram report Dr. 03/06/06
35. AP and lateral of the lumbar spine MHH Southwest 03/13/06 x 3
36. Interoperative electrophysiology monitoring 03/21/06
37. Follow-up evaluation Dr. 03/28/06
38. Progress noted Dr.
39. Follow-up evaluation Dr.
40. Operative note Dr.
41. Insurance claim 06/09/06
42. Radiology report lumbar myelogram xxxx 05/05/06
43. CT of the lumbar spine following myelography xxxxxx 05/05/06
44. Follow-up evaluation Dr. 06/27/06
45. Follow-up evaluation Dr. 08/01/06
46. Preauthorization review 09/18/06
47. Operative note Dr. 10/04/06
48. Insurance claim 10/04/06
49. Follow-up exam Dr. 10/06/06
50. Follow-up exam Dr. 12/01/06
51. Follow-up evaluation Dr. 04/10/07
52. Required medical evaluation Dr. 04/16/07
53. Follow-up evaluation Dr. 07/10/07
54. Preauthorization decision 09/18/06
55. Follow-up evaluation Dr. 10/30/07
56. Operative note Dr. 11/06/08
57. CT lumbar spine discography imaging department 11/06/08
58. MRI of the lumbar spine without contrast 08/19/08
59. Independent medical evaluation Dr. xxxxx 02/16/09
60. Letter from Dr. xxxxxx to Dr. xxxxx 05/12/09
61. Follow-up evaluation Dr. xxxxxx 07/28/09
62. Preauthorization report 10/05/09
63. Preauthorization report 08/07/09

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who apparently sustained an injury while at work when a table fell on him at his workplace. The employee reports being hit on the head and back in the accident. He reported experiencing neck and low back pain immediately afterwards with pain radiating into his left leg.

On 10/31/03, the employee was seen at xxxxx by Dr. He complained of pain 8/10 in his lower back with some mild neck pain. Upon evaluation, there was marked muscle spasm in the L5-S1, as well as point tenderness and restriction upon motion palpation. The employee also displayed muscle spasms, edema and point tenderness over the thoracic region T1-T5 over the right cervical musculature. Specific final adjustments were performed at C1, C5, T2 in the left side of the sacrum. Traction and moist heat were then applied. Post check revealed a decrease in point of tenderness and motion restriction. The employee was scheduled for 3 visits per week for 3 weeks to be followed by re-evaluation.

The employee followed-up on 11/03/03 with Dr. complaining of decreased pain 7/10. Evaluation displayed improved motion in the cervical and lumbar region upon motion palpation; however, there was still presentation of point tenderness and mild restriction. The employee was administered specific spinal adjustment to the mid cervical region, the upper thoracic and the left sacrum to reduce the subluxation present at these levels. The traction and heat were then applied. Post evaluation revealed improvement in motion and decrease in pain in the area. The employee was instructed to perform posterial exercises at home.

On 11/05/03, the employee followed up with Dr. and reported decreased pain 6/10. Evaluation displayed improved motion of his lumbar region upon motion palpation; however, there was still point tenderness, edema and mild restriction. Tenderness and compensatory muscle spasm was noted in the upper thoracic on the left, as well as over the right sacrum. The employee was administered specific spinal adjustment to mid cervical region, the upper thoracic region and left sacral region to reduce subluxation present at the respective levels. Traction and heat were then applied. Post evaluation revealed improvement in motion and decreased pain in the areas.

On 11/10/03, the employee followed-up with Dr. complaining of low back pain, left leg pain and neck discomfort rating pain at 8/10. Evaluation was performed which showed improved motion in the cervical region upon motion palpation; however, there was still presentation of point of tenderness. Global restriction was not evident, but there was a presentation of intersegmental restriction. Tenderness and compensatory muscle spasm were noted in the upper thoracic region in the left as well as over the right sacrum. The employee was administered specific adjustment to the mid cervical region, the upper thoracic region and the left sacral regions to reduce subluxation present at the respective levels. Traction and moist heat were then applied. Post-evaluation revealed improved motion and decreased pain in the areas.

On 11/12/03, the employee followed up with Dr. presenting with low back pain and left leg pain rating his discomfort 8/10. Evaluation displayed improved motion in the cervical region upon motion palpation. There was presentation of point tenderness and mild restriction at C5, tenderness and compensatory muscle spasms were noted in the

upper thoracic region on the left, as well as over the left sacrum. The employee was administered specific spinal adjustment to the mid cervical region, upper thoracic region, left shoulder and left sacral regions to reduce subluxation levels. Traction and moist heat were then applied. The employee informed of his desire to consult with an orthopedic surgeon due to persistent pain and discontinued care.

On 12/02/03, the employee presented for initial examination report by Dr. D.C. He reports he had been taking Aspirin for pain management. He states that the pain is worse in the morning and would get better as he becomes active. Physical examination, including orthopedic and neurological were unremarkable. His movements were guarded. He ambulated slowly. Deep tendon reflexes were performed on the biceps, triceps, brachial radialis, patella and Achilles. All reflexes were grade 2 and symmetric. Left hip extension, left hip flexion, left knee extension and left knee flexion were graded 4/5. The upper extremities were unremarkable. There was no sensory deficit in the upper or lower extremities. Cervical compression was positive in extension, right and left lateral flexion, right and left rotation. Cervical distraction was negative. Cervical range of motion was restricted moderately with pain in all planes. Kemp's test was positive on the left. Patrick's test was positive on the left. Miner's sign was present. Straight-leg raise was positive on the left. Braggard's was positive on the left. Thoracolumbar ranges of motion were moderately restricted with pain on flexion, right lateral flexion, left lateral flexion, right rotation and left rotation. Extension was severely restricted with pain. There was pain upon digital palpation of the cervical paraspinal musculature bilaterally in the C2-6 region. Intersegmental position was noted from C2-6 and L5-S1. Muscle spasm was also present in the mid cervical region, as well as the upper thoracic region on the right. Assessment was lumbar sprain/strain, cervical spinal strain, thoracic sprain/strain, sciatica. Treatment included specific spinal adjustment of the cervical, thoracic and lumbar spine adjunctive therapeutic activity consisting of moist heat, chiropractic therapy, mechanical traction and neuromuscular re-education. The prognosis was that the employee was to continue with a plan of care 3 times per week for 4 weeks.

On 01/06/04, the employee was evaluated by Dr. for pain management consultation. The employee reports he works at a school where is a janitor. He reports that when the table fell on him, he felt something pop in his back. He has been bothered with increasing pain in his left leg and numbness in his leg and foot. He reports his chiropractic sessions did little good. Currently, he is not taking any medication. On physical examination, there was active range of motion to the point of pain including more than 60 degrees on extension, flexion and rotation to the left, rotation to the right and side bending left 30-60. There is no tenderness or trigger points palpable. Side bending right was 30-60 degrees. Motor testing was normal bilaterally in the upper extremities. Sensory testing C4-T1 was normal. Reflexes were normal at the biceps, brachial radialis, triceps and his lumbar spine. Lordosis was normal. Scoliosis was non-evident. Lumbar list was not evident. No evidence of atrophy. No boney or soft tissue tenderness. There was painful muscle spasm on lumbar flexion, finger to floor distance was 0 cm. Lumbar hyperextension painful. Straight-leg raising with inclinometer left to 45 degrees, right 90 degrees. Patrick's test at the sacroiliac joints painful on the left. Motor nerve testing was normal bilaterally from L4-S1. Sensory was normal bilaterally at L4-5; however, diminished on the left at S1. Neurologic reflexes patellar was normal. Ankle jerk reflex diminished on the left. Impression was lumbar

radiculitis, lumbar sacral strain. The plan was to order an MRI of the lumbar spine. Follow-up in 2 weeks. A reported medical evaluation was completed by Dr. in which the employee was certified not to have reached MMI, but expected to reach MMI at about 02/01/04.

On 01/22/04, the employee underwent an MRI of the lumbar spine with and without contrast at xxxxx. Impression showed epidural fibrosis changes at L5-S1. There appears to be a protruded disc at the level L4-5 on the right side, although there is some gadolinium enhancement in this region suggesting a portion of this epidural fibroses. The L3-4 level reveals a protruded disc 4 mm as described.

On 02/03/04, the employee followed up with Dr. He complained of back pain and leg pain. He reports his pain continued. Physical exam limited to the lumbar spine. Straight-leg raise was positive on the left, negative on the right. He remains painful with hyperextension and positive Patrick's sign on the left. Diagnosis was lumbar radiculitis and possible lumbosacral stain. The employee continues to show sensory deficits in the left S1 distribution and positive straight-leg raise With the MRI in mind, the plan was to proceed with a lumbar selective nerve root injection at the level indicated on the MRI, left L3 and L4 in order to evaluate the amount of pain relief.

On 03/11/04, the employee underwent transforaminal epidural lumbar block at L4 and L5. The procedure was performed by Dr. On 03/18/04, the employee followed up with Dr. The employee complained of pain and cramping in the right hand which he had been experiencing over the last 3 days. He had been seen by Dr. and had an L3, L4 selective nerve root block. The employee reports his right hand pain has escalated over the last 3 days. The pain began in 09/03 at the time of the accident with his pain in his neck radiating to right shoulder and down the right arm to include the 4th and 5th digits. He complained of no sensory loss, no numbness or tingling, but occasionally had severe cramping in the right hand. Today he does not complain of any lack of strength, numbness or tingling or pain radiating to his hand. On physical exam, he had no motor or sensory deficits. His strength was 5/5 bilaterally with full sensation in the distribution at C1-8. The employee was given a prescription for Skelaxin and informed to follow-up with Dr. within the next 5 days.

On 03/24/04, the employee followed up with Dr. The employee reports the epidural steroid injection provided initial pain relief. He is still experience some significant numbness and a little bit of pain. He also has had more complaints in reference to his neck. He states that the pain begins in the cervical region and radiates down the right arm. He relates this onset to the accident with the table. He denies any weakness or sensory deficit. On examination of the cervical spine, there was tenderness to palpation in the cervical area. Left lateral side bending results in mild pain. There was no pain on hyperextension, right lateral side bending or flexion. There was no weakness identified or sensory deficit. At the lumbar spine, there was no pain on hyperextension or lateral bending. Straight-leg raise was negative on the left, positive on the right. No sensory deficit was noted. Diagnosis was cervicgia with possible cervical strain vs. cervical radiculitis. Lumbar radiculitis responded to a single epidural steroid injection. The plan was to obtain an MRI of the cervical spine. A prescription for Ultracet was provided. The plan was to proceed with a 2nd and 3rd series of epidural steroid injections since he

had such a good response to the 1st injection. On 07/09/04, the employee underwent epidural steroid injections involving the lumbar and sacral joints at right L3-4, L4-5 and L5-S1. The procedure was performed by Dr. on 08/13/04. The employee underwent an independent medical evaluation by Dr. neurological surgeon. The employee is a xx year old xxx who works as a xxxxx and a xxxxx at xxxx for xxxxx. He has worked in this position for the past 2 ½ years. On xxxxx, the employee was pushing a cafeteria table which fell on him and knocked him onto his back. He had onset of low back pain and left leg pain and neck pain. He has been treated by Dr. and Dr. He was provided epidural steroid injections to his lower back which reduced his symptoms for several weeks.

The employee underwent an MRI of the cervical spine on 05/06/04 which showed a herniated disc at the C7-T1 level and also disc herniation and spinal stenosis at C6-7.

On 08/13/04, the employee complained of low back pain which he stated was worse than his neck pain. The pain radiated down the posterior aspect of his left leg to the great toe and to the bottom of the foot. He also had numbness and tingling in the same distribution. He had no right leg symptoms or give way in either leg or symptoms of bowel or bladder dysfunction. He also complained of intermittent posterior neck pain and associated headaches. The pain seems to radiate down the left arm to the long finger. Associated symptoms also included numbness and tingling in the same distribution with left arm weakness. The employee denies any symptoms in the right arm. He reports that his symptoms have been temporarily relieved with the lumbar epidural steroid injections, medication and heat. On physical exam, there was decreased sensation to pinprick in the left C5, C6 and C7 dermatomes and decreased sensation to pinprick in the left L5 and S1 dermatomes. Otherwise, sensation is intact throughout both arms and both legs to pinprick and position. There was weakness of the left triceps, interossei and finger extension muscles. Otherwise, no other weakness was noted in any of the other muscle groups, in either arm or leg. Deep tendon reflexes were triceps jerk 1+ bilaterally, biceps jerk 2+ bilaterally, brachial radialis 1+ bilaterally, knee jerks 1+ bilaterally, ankle jerks 1+ bilaterally, plantar responses were down bilaterally. There was no clonus present in either side. Mechanical examination of the neck revealed Patrick's test and popliteal stretch test to be positive bilaterally, more pronounced on the left than the right. Straight-leg raise was positive bilaterally at 45 degrees with a bilateral positive Lasegue's sign, more pronounced on the left than the right. Mechanical examination of the neck revealed bilateral posterior paracervical and trapezius muscle spasm and tenderness to palpation which was much more pronounced on the left than on the right. Acute neck flexion produced very significant posterior neck pain. Testing for Spurling's signs was positive on the head turned in either direction, much more pronounced with the head turned to the left than to the right. No radiographs were provided at the time of evaluation. Impression was chronic left L5-S1 radiculopathy, possibly secondary to L3-4 and L4-5 herniated nucleus pulposus. Chronic left C6-7 radiculopathy, possibly secondary to C6-7 herniated nucleus pulposus. Recommendations: The employee is not capable of working at the present time. I do not see the need for any further injective therapy in either the cervical or lumbar regions. It seems that the employee's current treatment is definitely related to the original injury.

I believe that the treatment to date and possible future treatments are reasonable and necessary as a result of the original injury on 09/12/03. The employee should undergo a lumbar myelogram followed by a CT scan and an evaluation by a neurosurgeon as soon as possible. The employee may also require cervical myelogram followed by cervical CT scan and a neurosurgical evaluation regarding his neck problems after appropriate treatment of the lumbar problem has been accomplished. He may indeed require surgery. I see no need, at the present time, for formal physical therapy in view of the length of time since his original injury some 10 months ago.

On 08/24/04, the employee underwent lumbar facet blocks on the left at L3-4, L4-5 and L5-S1. The procedure was performed by Dr.

On 09/07/04, the employee followed up with Dr. to complain of back pain and left leg pain. The employee reports he had a transient response to his lumbar epidural steroid injection. He has been to an independent medical examiner doctor who recommends neurosurgical consultation which currently Dr. agrees with since he is still having pain in the low back and left leg. On physical examination, the employee exhibited positive straight-leg raise on the left, negative on the right. Impression was lumbar radiculitis. The employee was referred to Dr. for surgical evaluation.

On 10/19/04, the employee was evaluated by Dr. The employee reported over the past 6 months his pain has progressively worsened. He describes his discomfort as sharp and aggravated by sitting or turning and relieved by lying down and walking. The pain extends down the posterior thigh into the calf and foot. Back pain is rated as 5/10 and leg pain is rated as 5/10. Currently xxxxxx can walk up to 1 mile and sit for 20 minutes at a time before having to move. The employee also describes neck pain, which he rates as 6/10 with pain extending into his left arm and into the 2nd and 3rd fingers, as well as intrascapular region. His symptoms are aggravated by movement of the neck and relieved by sitting or changing positions. On physical exam, the employee's gait was normal. He was able to bend forward to touch the floor. He was able to extend his lower back to 10 degrees limited by pain. He can walk on toes and heels without difficulty. Cervical range of motion is flexion to chin with 1 finger breadth from chest. Right and left lateral rotations are 75 degrees each. Tenderness was noted in the cervical spine at the level C5-6. Axial compression was positive. Distraction test was positive. Spurling's sign was negative. In the lumbar spine, there was tenderness noted at the level of the waistline greater than at the base of the spine. Strength was 5/5 in both upper and lower extremities. Sensation was intact with minimal decreased sensation in the left L4-5, S1 dermatomal distributions. Reflexes are 1+ and symmetrical and toes are down going. Radiological evaluation, no previous studies were available to review. X-rays were obtained which show good overall alignment of the spine and slight narrowing of the disc space at L4-5. Recommendations: The employee is to obtain his previous MRI scan and follow up in a week for review. The employee was given a prescription for Bextra. Dr. suspected that the employee will have disc disease involving L4-5 and L5-S1.

On 12/07/04, the employee underwent MRI of the cervical and lumbar spine without contrast. The impression showed degenerative disc disease with central right paracentral 4 mm disc protrusion and ossified complex at C3-4. There is a small left central component at the present along with right sided uncovertebral hypertrophic

changes creating moderate stenosis and right sided foraminal narrowing. There is also degenerative disc disease with right paracentral and right lateral 4 mm disc protrusion osteophyte complex at the C6-7. A smaller left lateral component is present along the right sided uncovertebral hypertrophic changes creating moderate stenosis and right sided foraminal narrowing. There is a left paracentral 3 mm disc protrusion at C7-T1 creating compromise on the left side of the cord without significant foraminal narrowing. MRI of the lumbar spine impression shows degenerative disc disease with left paracentral foraminal HNP at the L5-S1 creating minor degrees of stenosis and left S1 nerve root compromise; 2) degenerative disc disease with right paracentral 3 mm disc protrusion osteophyte complex at the L4-5 along with moderate bilateral hypertrophic facet changes creating moderate stenosis and right L5 nerve root foraminal compromise; 3) degenerative disc disease with bilateral posterolateral 3 mm disc protrusion osteophyte complexes at L3-4 along with bilateral hypertrophic facet changes creating mild to moderate stenosis and bilateral foraminal encroachment.

On 12/14/04, the employee followed up with Dr. and he reports no change in his back pain and bilateral leg discomfort running into both the top and bottom of his feet, especially into the toes, left greater than right. Back pain and leg pain were both 9/10. He has also had urgency although no incontinence on examination. There was tenderness at the base of his spine only. MRI of the cervical and lumbar spine were reviewed. Recommendations: Surgical treatment options were discussed since he has failed non-operative care including rest, physical therapy, injections and his pain is quite severe. The employee's options were to continue living with his pain as it is, consider pain management or consider surgery. Of the two surgical options, one would be decompression and fusion at L5-S1, most likely involving a transforaminal lumbar interbody fusion or decompression with associated decompression at L3-5. Risks and complications were explained. The employee has decided to proceed with surgery. All questions were answered.

On 02/04/05, the employee underwent a designated doctor evaluation by Dr. The employee was assigned a 15% whole person impairment rating and was given a Maximum Medical Improvement dated of 02/04/05. Whole person impairment value was 5% impairment rating in the cervical region and 10% impairment rating in the lumbar sacral region for a total of 15% whole person impairment value. On 04/15/05, the employee underwent an additional requested medical evaluation with Dr. Pertinent neurological evaluation showed decreased sensation to pinprick in the left C5-6, C6 and C7 dermatomes. Also, decreased sensation to pinprick in the left L5-S1 dermatomes, otherwise sensation was intact to both arms and legs to pinprick impoosition. There was moderate weakness in the left interossei and extensor muscles. There was weakness in the left triceps muscles. No other lateralizing or localizing weakness was noted in any of the other muscle groups tested in either arm or leg. Deep tendon reflexes were triceps 1+ bilaterally, biceps 2+ bilaterally, brachial radialis 1+ bilaterally, knee jerks absent on the right, absent on the left. Ankle jerks trace on the right, absent on the left. Plantar responses were down bilaterally. There was no ankle clonus present. Mechanical examination of the neck revealed left posterial paracervical trapezius muscle spasm, tenderness to palpation, acute neck flexion produced posterior pain. Spurling's sign was positive with the head turned in either direction. Mechanical examination of the lower back reveals Patrick's test and popliteal stress test to be positive bilaterally. Straight-leg raising test was positive on the right at 45 degrees and

on the left at 30 degrees. There was a bilateral positive Lasegue's sign. Impression was chronic left L5 radiculopathy, chronic left C6-7 radiculopathy. Dr. proceeded to state that the employee has both cervical and lumbar herniated nuclear pulposus. He believes that these conditions are related to his initial injury of 09/12/03. His current treatment seems to be related to the injury and not specifically to ordinary diseases of life such as degenerative changes. The employee has received no chiropractic care and I do not believe that further chiropractic care is either reasonable or necessary. His current treatment definitely seems to be related to his work injury. His continued use of Bextra seems to also be related to the injury and both reasonable and necessary at this time. He will probably continue this medication for an undetermined amount of time in the future until he has definitive treatment for one or both of his conditions. He does not believe that any further physical therapy is reasonable or necessary since the employee is no longer receiving any physical therapy. His work-related injury has definitely not resolved. The employee is a candidate for surgery at the present time. The employee should proceed with lumbar surgery. The problem is he may also require a surgical procedure in the future if his cervical symptoms should persist. The employee, in his opinion, was not a candidate at the present time for a pain management program or work conditioning/hardening program. As far as treatment recommendations, he continued to recommend a lumbar myelogram followed by lumbar CT scan to determine the exact lumbar pathology. If indicated, he should proceed with lumbar surgery and if indicated by the lumbar myelogram and CT scan. The employee may also require evaluation for a possible radiculopathy if his symptoms indeed persist and are proven by an EMG done by a competent electromyographer to be a cervical radiculopathy. Dr. also included in his addendum I think that is absolutely essential that the employee have a lumbar myelogram followed by lumbar CT scan prior to any anticipated lumbar surgery so that the discrepancies between his first and second MRI scans be sorted out and see whether indeed he has true epidural fibrosis in his lower lumbar spine and to determine which level of the lumbar spine actually requires surgery. On 04//30/04, the employee underwent a transforaminal lumbar epidural block at multi-levels, L3 and L4 performed by Dr.

On 05/06/04, the employee underwent an MRI of the cervical spine without contrast which showed herniated discs at C7-T1, herniated disc with spinal stenosis at C6-7. At C5-6, there was an annular symmetrical bulge without compression of the cord. At C3-4, there was spinal stenosis with compression of the cord and alteration of cord contour. There was no compression of exiting nerve root sleeves. There was a mild defect measuring 1.6 mm.

On 05/25/04, the employee followed up with Dr. The employee had a very successful set of epidural steroid injections. The leg pain was gone for the most part. The employee had complaints of numbness and cramping in his leg. On physical exam, there was pain on standing, hyperextension, left lateral bending. Myofascial trigger points were present in the lumbar spine, especially on the left. Straight-leg raise was negative bilaterally. Impression: Herniated nucleuse propulses with lumbar radiculitis resulting in lumbar sacral strain. The plan: Employee was to be set for left sided facet joint injections. A prescription for Ultracet was provided. Follow-up in 2 weeks.

On 01/20/06, the employee followed up with Dr. He reports his back pain is getting worse with intermittent numbness in the bottom of the left foot. He has tried non-

operative care without significant improvement. The employee would like to proceed with surgery. On examination, there was tenderness not to palpation at the based of the spine. He walked with a flexed gait and motor examination showed 5/5 strength in bilateral lower extremities. Sensation subjectively diminished in the left L4, L5 and S1 distribution. X-rays showed decreased disc height at L4, L5 and S1. MRI showed entire disc disruption at L5-S1 with stenosis noted from L3-5. Two options were discussed with the employee. One was to continue as he is. The second option would be surgical intervention involving a transforaminal lumbar interbody fusion at L5-S1 and decompression from L3-5. Risks and complications were discussed. The employee would like to proceed with surgical intervention. On 03/07/06, the employee followed up with Dr.. The employee has decided to proceed with surgical intervention consisting of an L5-S1 fusion, possible decompression at the levels above to address his stenosis. Current complaints are primarily numbness and tingling extending into his feet. Therefore, we may decide to only perform the fusion at this time and leave the other levels unmolested. Recommendations: Risks and complications were discussed.

On 02/28/06, the employee underwent a chest x-ray for preoperative and surgical clearance. In addition, the employee underwent a consultation with cardiologist Dr. on 03/06/06 which cleared the employee to proceed with surgery from a cardiac perspective.

Echocardiogram from 03/06/06 was also reviewed which showed a normal ejection fraction of 55%.

On 03/13/06, the employee underwent surgical intervention involving interbody fusion at L5-S1, insertion of intervertebral body device L5-S1, posterior spinal elements at L5-S1, instrumentation from L5-S1 right iliac bone graft. Crest harvest through separate fascial incision, bone marrow aspiration of the left ileum, placement of structural graft, placement of uncial catheters. Surgery was performed by D. xxxxx. Perioperative views were taken of the lumbar spine to review placement of instrumentation. Also, intraoperative electrophysiology monitoring was provided during surgery.

On 03/28/06, the employee followed up with Dr. for first postoperative visit. The employee reports improved back pain. He states that his leg feels much better. His main concern was intermittent numbness in the bottom of his feet, which is more pronounced when he is sleeping at night which is positional related. Overall, he notes marked improvement of his back and leg symptoms. On examination, the employee's incision was well-healed without any signs of infection. There was no drainage or discharge noted. The employee was neurologically intact with no motor sensory deficits. X-rays of the lumbar spine were reviewed which show healing of the fusion mass in the posterolateral gutter, more pronounced on the right side. The instrumentation was intact at L5-S1 with no signs of hardware disengagement. Impression: The employee was doing very well following his TLIF interbody fusion at L5-S1. He currently is walking better. Recommendations: The employee should continue with his walking exercises. He was given a Vicodin refill for pain management. He was given a prescription regarding his intermittent numbness at the bottom of his feet. A prescription for Cymbalta may be considered if he does not improve. Follow-up in 4 weeks.

On 04/04/06, the employee followed up with Dr.. He reports he had some discomfort and intermittent numbness in the bottom of his feet. He was told to observe this and call the office if it got worse. The employee reports that his symptoms are progressing, that he is having problems with sleeping at night. The right leg pain and numbness are more positional related. He states that his back pain is much better compared to his preoperative symptoms. On physical exam, the incision was healing well without signs of infection. No discharge noted. He had no motor weakness or sensory deficit. X-rays were reviewed of the fusion which show a fusion mass in the posterolateral gutters, more pronounced on the right side. Instrumentation is intact at L5-S1 without any signs of hardware failure. Impression: The back pain is better. He is experiencing some right lumbar radiculopathy. Recommendation: The employee was started on Cymbalta 30 mg to be taken at night to help his lower extremity paresthesias, numbness, tingling and pain. The employee is to continue with Vicodin for pain management. Follow-up in 4 weeks.

On 05/05/06, he underwent a lumbar myelogram due to numbness in both feet. Impression showed status-post pedicle screw and anterior interbody fusion at L5-S1. Disc bulges at L3-4, L4-5 and L5-S1 with moderate spinal canal stenosis at L3-4, L4-5 that is partially relieved with changes in position. In addition to a CT scan of the lumbar spine, a myelography was performed. Impression showed status-post L5-S1 left laminectomy, left posterolateral interbody fusion and right posterolateral fusion with pedicle screws and interconnecting rods. The graft was immature. No abnormality of hardware was seen. Moderate spinal canal stenosis at L3-4, L4-5, moderate bilateral foraminal stenosis at L3-4 with moderate left foraminal stenosis at L4-5, moderate to severe right foraminal stenosis at L4-5, moderate right foraminal stenosis at L5-S1, the level of the fusion.

On 05/31/06, the employee underwent a transforaminal epidural steroid injection at bilateral L3 and L4 spinal nerves. The procedure was performed by Dr.

On 06/27/06, the employee followed up with Dr. The employee had undergone lumbar epidural steroid injections performed 2 weeks ago and reports he had a few days of pain relief in his right calf pain. The employee continues to notice significant pain in the anterior thighs bilaterally and also to the right calf which seems to be worse. Currently, he is seeking Vicodin for pain which helps. The employee has tried Cymbalta and Lyrica and both did not give him any significant improvement in the lateral feet numbness. On physical exam, the employee's back was non-tender to palpation. Motor examination was 5/5 in all muscle groups. Sensation was subjectively diminished in the L4 and L5 distributions bilaterally. There was slight diminished sensation in the L3 distribution. CT myelogram showed no significant nerve root compromise at the L5-S1 level. He is status-post L5-S1 transforaminal lumbar interbody fusion approximately 3 months ago. X-rays showed hardware intact at L5 and S1. The interbody device is also intact without any signs of hardware disengagement. Impression: The employee's symptoms appear to be coming from L3-4 and L2-3 levels. The L3-4 levels appear to be worse. Recommendations: Dr. discussed repeating the epidural steroid injection at the level L4-5; however, if this does not provide the employee with significant relief, a decompression may have to be considered. In the interim, the numbness and burning pain in the calf will be addressed with Neurontin 300 mg 3 times a day. The employee

was given Vicodin for pain control. He is to follow-up after his second epidural steroid injection is performed.

On 08/01/06, the employee followed up with Dr. complaining of worsening leg pain in the anterior thighs bilaterally all the way down to the bottom of his feet. He reports feeling miserable and would like to return to gainful employment. The employee has undergone a previous L5-S1 transforaminal lumbar interbody fusion approximately 4 months ago which gave him significant improvement in his back pain; however, he has been experiencing significant leg pain which has been getting worse. An L3-4 selective nerve root block was attempted which did not help. A repeat injection was recommended but this was denied by the insurance carrier. The employee continues to be miserable. He is currently taking Neurontin and does not notice any dramatic improvement. On examination, the employee's back is minimally tender to palpation at L3-4 and L4-5 levels. Motor examination shows strength to be 5/5. Sensation is subjectively diminished in the L3 and L5 distribution. CT myelogram shows less filling at the L2-3, L3-4 levels on the two views after critical examination of the films. There is significant stenosis at the L3-4 and L4-5 levels. The fusion seems to be incorporating well. Impression: The employee's symptoms appear to be originating from the levels above his prior fusion at the L3-4 and L4-5 levels. There is significant lumbar stenosis noted. Currently, he has lumbar radiculopathy and back pain. His back pain improved after L4-5 surgery. Recommendations: Several options were discussed with employee including repeating the nerve root injections at L2-3, L3-4 and L4-5 levels; however, this has been denied by the insurance carrier. The next step is to proceed with decompression of the worst areas, which appear to be L3-4, L4-5. The employee is to continue with Neurontin and Vicodin for pain control and numbness. The employee has decided to proceed with surgery. All questions were answered. Risks and complications were discussed.

On 09/18/06, a preauthorization for nerve root injections was approved.

On 10/04/06, the employee underwent a bilateral L4 spinal nerve epidural steroid injection. The procedure was performed by Dr. On 10/06/06, the employee followed up with Dr. after undergoing an L2-3, L3-4, L4-5 nerve root injection. The employee reports no change in his back and lower extremity pain. The employee is approximately 7 months out from his L5-S1 transforaminal lumbar interbody fusion. He continues to have back pain radicular to his pain to his anterior thighs. He reports numbness onto the bottom of his feet. He is quite frustrated with current conditions and symptoms. He has taken Neurontin, Cymbalta and Lyrica which have failed. On examination, there was tenderness above the waist level at the L2-3 level. Motor examination shows strength to be 5/5. Sensation is subjectively diminished in the L3 and L5 distribution. CT myelogram shows severe stenosis at L2-3 and L3-4 levels. There was a fusion mass which appears to be incorporating well at the L5-S1 level. Impression: Severe spinal stenosis at L2-3, L3-4 and status-post L4-5 fusion. Recommendations: A surgical decompression of L2-3, L3-4 was recommended to address his current symptoms. The employee has failed non-operative care including physical therapy, steroid injections and a trial of Neurontin. The employee is in agreement and would like to proceed with surgical intervention.

On 12/01/06, the employee followed with Dr. complaining of leg pain, mostly in bilateral thighs going into his ankles. He reports his back pain is tolerable at this point. The insurance carrier has continued to deny the surgical intervention involving L2-3, L3-4. He continues to take Neurontin and Vicodin for pain management. On examination, there was tenderness to palpation at the L2-3 level. Motor strength was 5/5 in all muscle groups of the bilateral lower extremities. Sensation was diminished in the L3, L4 and L5 distributions. CT myelogram showed severe stenosis at L3, L3-4, which are levels above his previous fusion at L4-5. Recommendations: Denial letter by insurance carrier was reviewed which Dr. stated to disagree with. The best interest of the employee would be to address the stenosis which is consistent with the description of his symptoms and also evidence of cervical CT myelogram.

On 04/10/07, the employee followed up with Dr. He continues to report that his lower back symptoms have significantly improved; however, he continues to have bilateral thigh pain which seems to be getting worse. Work-up thus far including CT myelogram, shows severe stenosis at L2-3 and L3-4 which are levels above the fusion. Recommendations were made in part in the past to decompress these levels which was denied by the insurance carrier. The employee recently underwent a prostatectomy on 02/07/07 for problems from which he has now recovered.

The employee reports he has on 04/16/07 with the Worker's Compensation referral physician. On examination, there was tenderness to palpation at the L2-3 level with decreased range of motion in the lumbar spine. Motor strength showed strength to be 5/5 in all muscle groups in bilateral lower extremities. Sensation was subjectively diminished at L3-4 and L5 distributions. CT myelogram showed severe stenosis at L2-3, L3-4. X-rays show hardware to be intact at the L4-5 level with no signs of fatigue or failure of hardware disengagement. Impression and Plan: Treatment options were discussed again which involved proceeding with decompression at the L2-3 level. Current recommendations consistent with the employee's symptoms and objective findings on CT myelogram. Surgery will be scheduled pending approval of the insurance carrier.

On 04/16/07, the employee underwent a required medical evaluation with Dr. Pertinent neurological examination showed sensation decreased in both feet and equal reflexes bilaterally. Position and sense is also decreased in both great toes; otherwise, sensation intact through both arms and legs to pinprick. On motor function testing, no lateralizing or localizing weakness was noted in any of the muscle groups tested and neither arm or leg. At times, the employee seemed to demonstrate lack of full effort on motor function testing and possibly a lack of understanding of the required action. Deep tendon reflexes were 1+ bilaterally in triceps, 1+ biceps bilaterally, 1+ brachial radialis bilaterally, knee jerk traces bilaterally, ankle jerks 1+ bilaterally. Plantar responses were down bilaterally, no signs of ankle clonus present. Mechanical examination of the neck revealed neck flexion to produce minimal posterior neck pain. Testing for Spurling's sign was only slightly positive with the head turned in either direction. Mechanical examination of the lower back reveals Patrick's test and popliteal stress test to be both slightly positive bilaterally. Straight-leg raise testing was positive bilaterally at 45 degrees and mildly positive Lasegue's sign bilaterally. Dorsalis pedis pulses were present bilaterally, stronger on the left than on the right. Lumbar myelogram, MRI of the cervical spine, intraoperative lumbar spine x-rays and lumbar myelogram of 05/05/06

and CT scan from 05/05/06 were reviewed. Impression: Minimal postoperative lumbar radicular symptoms including numbness of the legs. There was no significant low back pain, no significant lumbar radicular pain. Possible L4-5 disc herniation bulge which, in view of the employee's current lack of true lumbar radicular symptoms, I do not believe there is a surgical or minimal problem at the current time. No further evidence of cervical radiculopathy. Recommendations: Dr. strongly advised against any further surgery. The employee is capable of returning to work at this previous occupation as a school crossing guard. At this point, the employee should only take over-the-counter pain medication. The employee should return to see Dr. only on an every 4-6 month basis; however, the employee should not have any further surgery. The employee can obtain his medications through his primary care physician which he does not have at the present time. The employee was advised to seek out a primary care physician for his current blood pressure problems and other medications he might need. No further injective therapy is warranted at this time since he has not benefited from previous injections. As far as current and future treatment being reasonable and necessary, he agreed that both categories do apply and such treatment is related to the employee's original injury; however, any further treatment can be offered by a primary care physician. He strongly advised against any further physical therapy DME or any further surgical procedure on the employee. It seems that the symptoms of his leg numbness would not preclude him from returning to his previous occupation. He was warned that if he returns to his previous occupation, he should be careful about lifting and should ask for help with lifting that he may be requested to do. Any further surgery on the employee would likely result in the employee experiencing persistent symptoms which may be worse than those he currently has. On his addendum, he recommended a functional capacity evaluation if the employee is unable to return to his previous occupation. After reviewing the records and x-ray studies and examining the employee, the employee does have what appears to be a significant stenosis and disc bulging at L5-S1 which is not causing his current symptoms and bilateral leg numbness. Except for this numbness, the employee has recovered well from surgery. The employee does not have any significant low back pain or leg pain which may indeed preclude him from employment.

On 07/10/07, the employee followed up with Dr.. The employee reported that he continued to have severe low back pain which radiated around his hip and causes significant limitations with his ability to be active and what Dr. letter indicated of him only having numbness in his leg was absolutely not true and was not a correct representation of what he had said to Dr. The employee also has pain extending into his legs and feet. Dr. did point out some inconsistencies in the medical record. The employee was seen by his assistant earlier this year and he referred to the segment at L2-3 and L3-4 instead of L3-4 and L4-5. On examination, the employee is locally tender to both his pedicle instrumentation and at the level just above the surgical scar. The employee's symptoms extend down into his leg at the L4-5, L5 and S1 distribution. Dr. discussed with employee regarding his symptoms whether or not they cause significant impairment. If symptoms clearly are relatively mild or they cause little to no impairment, then surgery should not be indicated at this time. On the other hand, if the employee is miserable and the pain causes significant limitation in his ability to work and function, and if he is requiring significant use of analgesics, then the reasonable answer would be to consider surgical intervention. Previous CT myelograms have demonstrated disc bulges at the 3 levels above the fusion, L3-4, L4-5. The employee reported he is quite

miserable and restricted. He does not wish to continue as he is and he would like to proceed with surgical intervention once approved. On 10/30/07, the employee followed up with Dr. He continues to complain of increasing low back pain with shooting pain into his legs all the way down to the ankle, and to some degree to the top of his foot. The employee continues to have radicular pain to the lower extremities in what appears to be neurogenic claudication. On examination, there was tenderness to palpation 1 inch above the waist level all the way down to the base of the lumbar spine. Motor strength was 5/5 in all muscle groups of the bilateral lower extremities. Sensation was subjectively diminished at L3-4, L5 and S1 distributions. Impression and plan: The employee would like to proceed with surgical intervention. Dr. indicated with insertions made by Dr. and referenced by Dr. in his 08/24/07 review that there was no scientific evidence about the long-term effect of surgical decompression or a fusion for degenerative lumbar conditions. He believed those assertions to be completely false and can be disproven by a simple literature search which would bring up dozens of studies suggesting the effectiveness of arthrodesis. Dr. believes that although Dr. report was very thorough, he did not believe that Dr. had sufficient extensive training involving lumbar arthrodesis; therefore, he did not have the experience that spine specialists with different backgrounds may have since it is clearly written that arthrodesis can indeed provide significant in employees with degenerative conditions of the spine. Particularly spondylolisthesis, but also spondylosis. In scientific literature referred to by Dr. Preston in his letter, it is largely literature that is more than 10-15 years old and is likely of little relevance today. He agrees with Dr. that steroid injections are not indicated since previous trials were ineffective and that additional therapy would not have much hope of giving the employee any additional benefit. Currently, the employee has segmental stenosis which is moderate to severe at L4-5 and mild to moderate at L3-4. He also has tenderness over his pedicle instrumentation. The employee's leg symptoms extend down to L4-5 and S1 distribution. The employee denies that he told Dr. he was having minimal to no pain and states that, in fact, his pain is quite problematic both across his back and into his legs. He disagrees with the treatment of spondylitic changes and spinal stenosis have not been shown to be beneficial to employees in surgical literature. This is also not the position of the North America Spine Society or other academic spine institutions. The employee should be re-evaluated by an appropriate specialist. It may be reasonable to consult with a fellowship trained spine surgeon to see if there may be room for difference of opinion with Dr.

On 08/19/08, the employee underwent an MRI of the lumbar spine without contrast. The impression showed transitional lumbar sacral junction is present, definitive vertebral numbering may be required counting down from the C2 level. Anterior and posterior fusion at the L5-S1 was shown with recurrent residual central and right posterolateral partly into foraminal protrusion. Spondylosis displacing the proximal right S1 root effacing fat from the lateral recess. At L3-4 and L4-5 there were diffuse annular bulges with inferior foraminal encroach and narrowing bilaterally. On 11/06/08, the employee underwent a discogram of L3-4 and L4-5. Findings showed decreased annular degeneration with lateral and subligamentous disc protrusion. Despite this, provocation was negative to a maximum pressure of 112 PSI at L3-4. At L4-5, the discogram showed diffuse annular degeneration with subligamentous disc protrusion. Provocation with injection was negative. On 11/06/08, the employee underwent a CT lumbar spine with post-discography at imaging department. Impression showed at L3-4 there was a nuclear pacification with bilateral foramina annular tearing. There is 8 mm of left

foraminal disc herniation and 5 mm on the right. There is a marked left foraminal narrowing and moderate to marked right sided stenosis. Moderate to marked canal stenosis is seen with facet hypertrophy. At L4-5 there is nuclear pacification and diffuse annular tearing with 4 mm of right foraminal disc protrusion. There is moderate to marked narrowing of the canal with facet hypertrophy, moderate to marked left foraminal narrowing is seen with marked right sided stenosis. At L5-S1, the employee is status-post discectomy and graft and no injection was performed. No canal stenosis is seen. Moderate foraminal narrowing is present. Early areas of the bridging around the graft are noted with solid posterolateral fusion bilaterally.

On 02/16/09, the employee underwent an independent medical evaluation performed by Dr. The question was Is proposed surgery required and necessary involving a posterior lumbar decompression with possible extension of fusion? The response was that the employee had focal areas of spinal stenosis prior to his operative procedure in 2006. He believes that the procedure being performed caused compression of the thecal sac at L4-5 immediately after fixing the relationship of L5-S1. The biomechanics have been altered and with rather significant spondylitic changes at L3-4. He has developed spinal stenosis between L3 and L5. He does not believe that this may have been symptomatic before surgery. He does not believe that the hallmarks and the anatomy were certainly there before. At present, he believes that the changes have occurred as a result of the injury and the subsequent surgery and changing mechanics of his back between L3 and L5. He reports that he is quite aware that he does not produce any large translation of movement at L3-4 and L4-5, but there is a high grade stenosis at both levels. There is also evidence of deteriorating facets, especially at L3-4.

A letter to Mr. from Dr. was reviewed on 05/12/09 requesting the employee to undergo dorsal medial branch block above his fusion with diagnostic epidural steroid injection. On 07/28/09, the employee followed up with Dr. The employee reports he had injections with Dr. office and he states that he did obtain partial relief for several days with his back pain. Unfortunately, most of his pain is in his legs rather than his back. He describes the pain as being positional when he sits down or lies down. He has no pain when he stands or walks for a few moments. The symptoms have worsened. The symptoms extend down into the anterior thighs and lower legs. He feels that is his primary pain, and that the back pain is relatively mild. His only concern at this time is his leg pain. On physical exam, the employee's back is entirely non-tender to palpation. MRI of the lumbar spine reveals stenosis at 2 levels above his fusion, L2-3, L3-4. The plan: Several options were discussed including additional injection medication or considering surgical intervention. Surgical intervention involves a simple laminectomy combined with the use of interspinous process spacer. The advantage of the spacer is that we may be able to perform a more limited laminectomy which may have less risks of progressing to instability and need for extension of his fusion in the future. In order to consider the use of intraspinous process spacer, a bone density study must be performed to ensure that his bones are strong enough to benefit from the device. If the bone density is scored to signify to osteopenia, will indeed need to start on a bifosfonate and will limit the surgery to a laminectomy only. Risks and complications were discussed. Surgical intervention involved laminectomy and placement interspinous process spacer at the 2 levels above L2-3 and L3-4. A preauthorization report dated 10/05/09 was reviewed in which the request for laminectomy with placement of interspinous spacer at L2-3, L3-4 was denied.

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

The request is not supported by the *Official Disability Guidelines*. The MRI dated 08/19/08 reported that the T12-L3 levels were unremarkable. L3/4 did note evidence of a 4-5mm bulge with mild facet arthropathy and bilateral foraminal narrowing however L4/5 also noted moderate degenerative changes and moderate canal stenosis. It therefore does not meet guidelines at this time. There is no evidence that L4/5 is not a surgical level or that L2/3 is a surgical level and no more than two surgical levels would be allowed per the guidelines. Also, the lack of bone density studies support denial as ruling out osteoporosis is a requirement.

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

1. *Official Disability Guidelines*, Low Back chapter, Online Version
2. Zucherman JF, Hsu KY, Hartjen CA, Mehalic TF, Implicito DA, Martin MJ, Johnson DR 2nd, Skidmore GA, Vessa PP, Dwyer JW, Puccio ST, Cauthen JC, Ozuna RM. A multicenter, prospective, randomized trial evaluating the X STOP interspinous process decompression system for the treatment of neurogenic intermittent claudication: two-year follow-up results. *Spine*. 2005 Jun 15;30(12):1351-8.