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Notice of Independent Review Decision

DATE OF REVIEW: 09/03/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Input Lumbar 360 Fusion 2 day LOS L5-S1 63090 22558 22851
20931 22612 63047 22842 20931 95920

**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:

Denials Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 11/25/08 - MRI Lumbar Spine
2. 04/27/09 - MRI Lumbar Spine
3. 06/10/09 - MRI Lumbar Spine
4. 06/10/09 - Operative Report
5. 07/29/09 - Clinical Note -, MD
6. 08/26/09 - Clinical Note -, MD
7. 10/15/09 - Clinical Note -, MD
8. 11/12/09 - Emergency Room Report
9. 11/12/09 - MRI Lumbar Spine
10. 12/02/09 - Independent Medical Evaluation
11. 05/25/10 - Required Medical Evaluation
12. 06/07/10 - Clinical Note -, MD
13. 06/22/10 - MRI Lumbar Spine
14. 07/15/10 - Clinical Note -, MD
15. 07/19/10 - Clinical Note -, MD
16. 08/13/10 - Clinical Note -, MD
17. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx when she lifted a five gallon bucket and felt something pop in her back.

The clinical notes begin with an MRI of the lumbar spine performed 11/25/08 that demonstrated a 3 mm disc bulge, facet osteoarthritis, and mild bilateral neural foraminal narrowing at L4-L5. There was a 10 mm midline disc protrusion at L5-S1 that filled the majority of the spinal canal causing spinal canal stenosis. There was also a 4 mm posterior spondylolisthesis at L5 on S1, disc height loss, and disc desiccation as well as facet osteoarthritis.

An MRI of the lumbar spine performed 04/27/09 demonstrated recurrent disc herniation at L5-S1 that extended or measured 15x20 mm and caused some central canal stenosis. There was some enhancement along the dural surface inferior to this disc herniation. There was an 8 mm retrolisthesis at L5-S1. The remaining levels revealed minimal bulges but no neurologic impingement. There was moderate facet arthropathy bilaterally at L3-L4 and L4-L5.

The employee underwent an L5-S1 revision discectomy on the right with nerve root monitoring on 06/10/09.

An MRI of the lumbar spine performed 06/10/09 demonstrated status post laminectomies at L5-S1. There was prominent enhancing soft tissue within the anterior aspect of the spinal canal at L5-S1 extending behind the S1 level. This surrounded the proximal S1 nerve root sleeves and abuted the anterior and lateral margins of the thecal sac. There was a small focal region of non-enhancement noted within the left anterior aspect of the spinal canal. There was a 2 to 3 mm annular bulge at L4-L5 without signs of central canal stenosis. There was retrolisthesis of L5 on S1 with disc desiccation and disc space height loss. There were small anterior osteophytes seen. There was a small focal region of T2 hyperintensity within the right kidney, likely related to a renal cyst.

The employee was seen in the emergency room on 11/12/09 with complaints of back pain. The employee stated the pain was severe. The employee denied bladder or bowel dysfunction. Physical examination revealed severe vertebral point tenderness over the lower lumbar spine. An MRI of the lumbar spine performed 11/12/09 demonstrated a stable herniated nucleus pulposus at L5-S1 and stable mild bulging annulus fibrosis at L4-L5. The employee was assessed with chronic back pain. The employee was prescribed Darvocet-N 100, Flexeril 10 mg, Ativan, and Phenergan.

The employee was seen for an Independent Medical Evaluation (IME) on 12/02/09. The employee complained of pain in the back, both hips, and both legs. The employee reported numbness and weakness of the right leg and foot. The employee stated she had to catheter herself four times daily in order to decompress her bladder. Physical examination revealed the employee used a

walker for ambulation. The employee ambulated with a limp and a pronounced right foot drop. Range of motion of the back was severely decreased. There were no muscle spasms noted. Straight leg raise was positive bilaterally. There was marked weakness of the right tibialis anterior and extensor digitorum longus. There was loss of sensation to light touch and two-point discrimination on the right foot. There was no proximal muscle atrophy. The employee's compensable injuries were noted to be related to her back. The employee's disability, to include right leg weakness, right leg foot drop, right leg sensory loss, and neurogenic bladder, were noted to be a direct result of the work related injury.

The employee saw Dr. on 06/07/10 with complaints of severe low back pain and right leg weakness. The employee ambulated with the use of a rolling walker. The employee was unable to void independently, and she had to catheterize herself at least four times daily. The employee was unable to void stool independently. Physical examination revealed no hyperreflexia. There was numbness in the L5-S1 distributions on the right side. The employee had a severely antalgic gait favoring her right leg. The employee was assessed with history of cauda equina syndrome and L5-S1 herniation with discectomy and revision. The employee was recommended for MRI of the lumbar spine. The employee was referred for urological evaluation. It was felt that the employee would require a L5-S1 definitive fusion.

An MRI of the lumbar spine performed 06/22/10 demonstrated chronic loss of disc height with reactive endplate changes at L5-S1 and mild retrolisthesis of L5 on S1. There was considerable peridural enhancement around the surgical bed. The decompression appeared adequate. There was residual tissue in the anterior extradural space interposed between the two S1 roots without compression. It was felt this may reflect chronic reactive granulation tissue to the previous disc herniation or secondary tissue reaction to a recurrent disc herniation. At L4-L5, there was a broad-based disc bulge associated with an annular tear on the right without impingement.

The employee saw Dr. on 07/19/10. Physical examination revealed severe weakness in the right gastrosoleus and right anterior tibialis. Tension signs were positive reproducing back pain and right leg pain. The employee was felt to be a candidate for spinal fusion.

The request for Inpatient Lumbar 360 Fusion 2 Day LOS L5-S1 63090 was denied by utilization review on 07/27/10 due to lack of documentation of instability on imaging studies or discussion that the rationale for fusion is the wide dissection including facetectomy will create surgically induced instability.

The request for Inpatient Lumbar 360 Fusion 2 Day LOS L5-S1 63090 was denied by utilization review on 08/04/10 due to lack of objective documentation of the employee's clinical and functional response from the mentioned epidural

steroid injection that includes sustained pain relief, increased performance in the activities of daily living, and reduction of medication use.

The employee saw Dr. on 08/13/10. The note stated the employee had undergone lumbar discectomy twice. She had recurrent disc herniation at L5-S1. The employee reported chronic back pain, right leg pain, right leg weakness, and urological dysfunction. Physical examination revealed severe weakness in the anterior tibialis, extensor hallucis longus, and gastrocnemius. Tension sign remained positive on the right sign reproducing back pain and right leg pain. The employee was wearing an AFO brace. The employee was assessed with L5-S1 discectomy, recurrent disc herniation at L5-S1, and chronic cauda equina syndrome. The employee was recommended for a combined anterior and posterior fusion as the area was at a high risk for nonunion.

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

Based on the clinical documentation provided for review and review of the prior denials, the requested lumbar 360 fusion with 2 day length of stay is within standard of care and medically necessary. The employee is status post two lumbar laminectomies at the L5-S1 level that failed to improve the employee's low back and lower extremity symptoms. The imaging reports provided document progressive spondylosis at L5-S1 with degenerative endplate changes and a possible recurrent disc herniation vs. significant epidural scarring. The employee on examination has clear evidence of cauda equina syndrome that will most likely worsen without surgical intervention. Current evidence-based guidelines recommend lumbar fusion for mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Additional conservative care would not reasonably improve the employee's functional deficits at this point in time. In this case, documented motion segment instability is not a primary consideration for surgery and insufficient documentation of response to prior epidural steroid injections would not negate the need for surgical intervention in this case. The progressive collapse of the L5-S1 segment would most likely become worse over time, and the employee would require a 360 degree procedure to stabilize the segment.

As such, the requested lumbar 360 fusion with 2 day length of stay is medically necessary.

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

1. *Official Disability Guidelines*, Online Version, Low Back Chapter