



## 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

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 03/08/11

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: Inpatient lumbar surgery to include lumbar laminectomy, discectomy at L3-4-5-S1; arthrodesis with cages, posterior instrumentation L5-S1 and 3 day length of stay.

22840, 22558, 22899, 63030, 63035, 69990, 22612, 22851, 20938, 22325

**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. An M.D., 10/19/09, 12/03/09, 01/13/10, 02/22/10,
2. Diagnostic Imaging, 10/26/09
3. Pain management follow-up visit, 03/03/10
4. An M.D., 04/06/10, 01/02/11
5. Psychological evaluation, 05/26/10
6. 06/29/10, 02/08/11, 02/15/11
7. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The medical records available for review indicate the employee sustained an injury to her lumbar spine. The employee felt a twinge in her low back and she experienced intense back pain and could not rise from the floor. The employee was administered an i.v. morphine and transported by ambulance to a hospital emergency room.

The employee treated with an M.D. There was a lumbar MRI ordered which revealed disc protrusions at L3-L4, L4-L5, and L5-S1. An EMG/NCV indicated radiculopathy at the S1 level.

On 10/19/09, the employee presented for an initial evaluation with the Dr.

There was a lumbar MRI on 10/26/09. The impression was disc protrusions lower lumbar spine with disc protrusion/extrusion at L5-S1.

On 01/13/10, the employee saw the Dr. It was noted she was making slow progress with physical therapy, medications, and work restrictions.

The employee saw the Dr. on 02/22/10. She presented for reevaluation, and on that date, the impression was moderate severe sprain, moderate severe left SI joint sprain, left SI radiculopathy, and possible L5 involvement. She was to restart physical therapy.

There was a pain management follow-up visit on 03/03/10. It was noted the employee had good relief in her low back but continued to suffer from significant pain in her left leg. The employee indicated she did not wish to pursue a second injection and would like to see a surgeon for further treatment options.

The employee presented to an M.D., on 04/06/10, who reviewed the MRI scan of the lumbar spine which indicated L4-L5 and L5-S1 non-contained disc herniation rated at stage 3 with annular herniation, nuclear extrusion, and spinal stenosis.

There was a psychological evaluation on 05/26/10 for presurgical psychological evaluation. The employee's history and presenting problem was reviewed. The employee indicated that her pain affected her ability to do normal activities. Her pain limited her ability to do things with family, sports, hobbies, and driving. Her current medications included Hydrocodone, Naprosyn, Lexapro, and methalcarbonal. She denied any personal history of emotional disturbance. The employee obtained a score of 88 on the pain and impairment relationship scale. The impressions and recommendations were from the clinical interview. The employee was found to have the following risk factors: chronicity of condition. From the clinical interview and testing, the employee was to have to have the following risk factors: significant reactive depression, anxiety, and tendency to see herself as disabled by pain and limited functioning ability. The clinical interview tested data suggested the employee was considered to be a fair risk for surgery and from a psychological perspective.

There was an office visit on 01/02/11 with an M.D. It was noted she had won her Contested Case Hearing and was allowed to proceed with surgical intervention. It was noted she was previously cleared for a decompressive lumbar laminectomy/discectomy at L3-L4, L4-L5, and L5-S1 with instrumented arthrodesis at L5-S1 only. X-rays of her pelvis revealed hips without degenerative joint disease, sacroiliac joints without sclerosis, and no focal findings. The assessment was lumbar herniated nucleus pulposus, L3-L4, L4-L5, and L5-S1 with clinical instability at L5 and S1 with failure of conservative treatment.

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

After a comprehensive review of the medical information provided for this request, this employee does not have accepted indications for an arthrodesis surgery. Her lumbar MRI reports a disc protrusion/extrusion at L5-S1 with significant degenerative joint disease at L3-L4, L4-L5, and L5-S1.

***Official Disability Guidelines*** criteria for spinal surgery includes documented evidence of instability.

The Dr's dictations refer to flexion/extension views that show instability at L5-S1. However, the medical records provided for this review do not contain a confirmatory opinion from a radiologist. There is limited evidence of success for arthrodesis in degenerative conditions.

This file does not contain recommended indications of documented instability. The guides require translation of 4.5 mm or more at the unstable area or an increase in the angle of over 20 degrees. These medical records do not contain evidence that any of these criteria exist in this employee.

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

***Official Disability Guidelines***