



## **IMED, INC.**

1819 Firman • Suite 143 • Richardson, Texas 75081  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

---

### **NOTICE OF INDEPENDENT REVIEW**

**NAME OF EMPLOYEE:**  
**IRO TRACKING NUMBER:** M2-06-1469-01  
**NAME OF REQUESTOR:** Injured Employee  
**NAME OF CARRIER:** Zurich Holding Company of America  
**DATE OF REPORT:** 07/13/06  
**IRO CERTIFICATE NUMBER:** 5320

#### **TRANSMITTED VIA FAX:**

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by an M.D. physician reviewer who is Board Certified in the area of Orthopedic Surgery and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the provider, the injured employee, injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

#### **REVIEWER REPORT**

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

**Information Provided for Review:**

- Medical records of Dr. Shen Chen.
- MRI of the lumbar spine dated 10/27/04.
- Medical records of Dr. Johnny Qubty.
- Medical records of Dr. James Cabel.
- Lumbar discography dated 08/12/05.
- Consultation report of Dr. Albert Telfeian.
- Medical records of Dr. Shawn Henry.
- Medical records of Dr. Jack McCarty.

**Clinical History Summarized:**

The injured employee reported development of low back pain after attempting to transfer a patient from a hospital bed to a recliner on \_\_\_\_.

09/28/04 – X-ray of the lumbar spine. The impression was six lumbar shaped vertebral bodies with lumbarization of S1 which was slightly asymmetric and may be the source of the employee's pain. Otherwise, normal lumbar spine.

09/27/04 – Shen Chen, M.D. Assessment was acute low back sprain/strain injury with severe low back pain. Soma was given orally three times daily. The injured employee was to return in a few days. Vicodin one every four to six hours as needed for pain. The employee was to rest at home for two days and restricted work.

09/30/04 – Shen Chen, M.D. Assessment acute low back sprain/strain injury with continued pain. Dr. Chen wanted to schedule physical therapy three times a week for four weeks. Injured employee continued off work and medications.

10/06/04 – Shen Chen, M.D. Assessment acute low back sprain/strain. Employee continued with physical therapy three times a week for four weeks, as well as continued with restricted work. Vicodin one every six hours.

10/20/04 – Shen Chen, M.D. Assessment low back sprain/strain. Employee was to continue with physical therapy. Dr. Chen recommended magnetic resonance and bone scan with contrast of the lumbar spine and continued restricted work.

10/27/04 – MRI of the lumbar spine by Richard Tajares, M.D. The conclusion was significant degenerative disc disease at L5-L6, lumbar disc with small central disc protrusion, moderate narrowing of the central canal at L5-L6, six lumbar type vertebra.

**Case No.: M2-06-1469-01**

**Page Three**

11/03/04 – Shen Chen, M.D. It was recommended that the injured employee continue with home medications, restricted work, and physical therapy. Dr. Chen wanted a pain specialist consultation with Dr. Qubty.

11/06/04 – Johnny Qubty, M.D. Assessment on that day was L5-L6 protrusion with lumbalgia and lower extremity radiculitis. The plan was an L5-L6 epidural steroid injection, Valium, Naprosyn, Skelaxin, and Ultracet.

11/17/04 – Assessment low back sprain/strain. The plan was to continue physical therapy, restricted work, and follow-up with Dr. Qubty.

12/15/04 – Shen Chen, M.D. Assessment lower back sprain/strain injury and L5-L6 protrusion with lumbalgia. The plan was to continue with physical therapy two times a week for four weeks and continue follow-up with pain specialist, Dr. Qubty and continued restricted work status.

01/27/05 – Shen Chen, M.D. Assessment lower back sprain/strain and L5-L6 protrusion with lumbalgia. The plan was continued restricted work and follow-up with Dr. Qubty.

01/27/05 – Progress note from Johnny Qubty, M.D. The plan was right L4-L5-L6-S1 facet median nerve branch block, as well as Lidoderm Patches #30.

02/17/05 – Shen Chen, M.D. Assessment lower back sprain/strain and L5-L6 protrusion with lumbalgia. The plan was continued restricted work and follow-up with Dr. Qubty.

03/17/05 – Shen Chen, M.D. Assessment lower back sprain/strain and L5-L6 protrusion and lumbalgia. The plan was follow-up with Dr. Qubty, continued restricted work, and the employee was told to see her family doctor for follow-up with blood pressure.

04/01/05 – Shen Chen, M.D. Dr. Chen wanted to refer the injured employee to doctors at the Texas Back Institute.

05/03/05 – James Cabel, M.D. Impression low back pain with disc disruption and failure of conservative treatment. Dr. Cabel recommended that they proceed with discography. Dr. Cabel agreed that the injured employee would not be a candidate for nucleoplasty or IDET, but could be a candidate for disc replacement or fusion.

05/04/05 – Shen Chen, M.D. Dr. Chen was awaiting Dr. McCarty and Dr. Cabel's report. The employee was continued with restricted work.

**Case No.: M2-06-1469-01**

**Page Four**

06/08/05 – Shen Chen, M.D. The injured employee was to follow-up with back specialist, Dr. Cabel and continued work restrictions.

07/13/05 – Shen Chen, M.D. The injured employee was told to see her family doctor concerning her blood pressure. Dr. Cabel's TWCC-73 was reviewed and indicated the injured employee was unable to work from 06/28/05 through 08/28/05.

08/12/05 – Operative report from David Hagstrom, M.D. Findings normal L4-L5 disc not painful. Concordantly painful L5-L6 disc with posterior disc protrusion, and concordantly painful L6-S1 disc with faint appearance of contrast in extrusion pattern posteriorly.

08/30/05 – James Cabel, M.D. Injured employee returned for follow-up.

08/31/05 – Shen Chen, M.D. The injured employee was to continue with home medications as needed. Dr. Chen also had a TWCC-73 from Dr. Cabel stating that the employee could not work from 08/30/05 through 11/30/05.

10/03/05 – Albert Telseian, M.D., Ph.D. Dr. Telseian reviewed the injured employee's MRI films and did not reveal sufficient pathology to warrant neurosurgical evaluation.

10/18/05 – Shen Chen, M.D. Assessment that date was chronic low back pain and L5-L5 protrusion.

10/27/05 – A Designated Doctor Evaluation by Jack McCarty, D.O.

11/30/05 – Shen Chen, M.D. Continued restricted work, continued medications.

12/30/05 – Shen Chen, M.D. Injured employee still unable to work, and Dr. Chen wanted the injured employee to see Dr. Hagstrom, pain specialist, for follow-up.

01/20/06 – Shen Chen, M.D. Injured employee still off work.

02/03/06 – Shen Chen, M.D. Dr. Chen wanted to refer injured employee back to Texas Back Institute and Dr. Hagstrom.

02/14/06 – James Cabel, M.D. The injured employee had positive sitting root test, right greater than left, tenderness at L5-S1. The injured employee had decreased sensation, especially involving the lateral aspect of the right leg possibly involving the medial aspect. Dr. Cabel recommended a surgical consultation.

**Case No.: M2-06-1469-01**  
**Page Five**

02/27/06 – Shawn Henry, D.O. Injured employee presented for consultation. Assessment L5-L6 and L6-S1 concordant description of pain with normal control. Dr. Henry offered the injured employee the opportunity for a fusion to treat the discogenic pain. The injured employee wanted to go ahead with the surgery.

03/27/06 – Shawn Henry, D.O. Injured employee returned to Dr. Henry who reviewed her studies. The injured employee's MRI scan revealed significant disc desiccation with central disc protrusion and annular tear.

04/17/06 – Shawn Henry, D.O. Injured employee returned for follow-up.

04/20/06 – Shen Chen, M.D. Assessment intractable low back pain and L5-L6 protrusion with lumbalgia. The plan was a consultation with a bone specialist and pain specialist. The injured employee was still unable to work.

05/01/06 – Follow-up with Shawn Henry, D.O.

05/24/06 – Shen Chen, M.D. Assessment chronic intractable low back pain and L5-L6 protrusion. Noted that the injured employee was pending consultation with Dr. McCarty for Maximum Medical Improvement (MMI) and impairment rating evaluation. The injured employee was still unable to work.

05/30/06 – Designated Doctor Evaluation, Jack McCarty, D.O. The diagnosis was severe degenerative disc disease at L5-L6 with small central disc protrusion L4-L5 noted. Positive discogram on last two levels. Dr. McCarty stated that the injured employee was not at MMI.

06/07/06 – Shen Chen, M.D. Assessment chronic intractable low back pain. Dr. Chen noted that Dr. McCarty's MMI and impairment rating were reviewed. The injured employee still unable to work and was to follow-up with specialist as instructed.

**Items(s) In Dispute:**

Preauthorization denied: Lumbar 360 fusion.

**Decision:**

Denial upheld.

**Rationale/Basis for Decision:**

The available medical record indicates a great deal of variability in examination results between the employee's treating providers. The imaging studies and medical history do not establish the need for a 360 degree fusion procedure. The records do not contain any flexion or extension films to indicate instability of the motion segments. A less invasive procedure may be appropriate, especially in the presence of comorbid diabetes. This employee has increased risk for postoperative infection and/or pseudoarthrosis. The employee has previously been consulted by Dr. Albert Telfeian, a neurosurgeon, who opined the employee was not a surgical candidate.

Spinal fusion is not recommended for workers' compensation patients in the absence of fracture, dislocation, or instability. There is no scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. There is no good evidence from controlled trials that spinal fusion is effective for treatment of any type of low back problem, in the absence of spinal fracture or dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Persons with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis may be candidates for fusion. It is important to note that although it is being done, lumbar fusion for general back pain very seldom cures the patient. A recent study has shown that only 29% assessed themselves as "much better" in the fusion group versus a 17% complication rate (including 9% life threatening or re-operation). Another clinical trial found that the success rate of lumbar fusion was less than or equal to noninvasive therapy, exercises for three weeks and a lecture.

A recent clinical trial concluded that patients with chronic low back pain who followed cognitive intervention and exercises programs improved significantly in muscle strength compared with patients who underwent lumbar fusion. A recent study on improving quality through identifying inappropriate care found the use of guideline-based **Utilization Review** protocols resulted in a denial rate for lumbar fusion fifty-nine times as high as denial rates using non-guideline based **Utilization Review**. Lacking review criteria linked to clinical evidence, **Utilization Review** organizations may become "risk averse" in denying care. There is no evidence that spinal fusion surgery is any more beneficial than intensive rehabilitation. Lumbar spinal fusion surgeries use bone grafts and are sometimes combined with metal devices to produce a rigid connection between two or more adjacent vertebrae.

The therapeutic objective of spinal fusion surgery for patients with low back problems is to prevent any movement in the intervertebral spaces between the fused vertebrae, thereby reducing pain and any neurologic deficits. Various theoretical rationales are given for the use of fusion in patients with low back problems. One theory postulates that in cases of significant spinal instability (abnormally increased motion at an intervertebral level), fusion prevents painful

compression of the neural structures. Another controversial theory holds that, in some cases, back symptoms arise from the disc itself and fusion relieves symptoms by greatly reducing forces compressing the disc. Disc degeneration at the mobile segment next to a lumbar spinal fusion is now considered a potential long-term complication of spinal fusion that can necessitate further surgical intervention and adversely affect outcomes.

The profit motive and market medicine have had a significant impact on clinical practice and research in the field of spine surgery. Industry funded studies demonstrated a statistically greater likelihood to report positive results than studies with other funding sources. Data on geographic variations in medical procedure rates suggest that back surgery rates are more variable than many other types of surgery, and that spine fusion rates are more variable than spine surgery rates in general. This finding is usually interpreted to suggest a poor professional consensus on the appropriate indications for performing spinal fusion.

Workers' compensation has been associated with especially poor outcome after surgery. Presurgical predictors of poor outcomes from fusion are the number of prior low back operations, low household income at the time of injury, older age, lawyer involvement, and the presence of depression. In acute spinal cord injury, if the spine is unstable following injury, surgical fusion and bracing may be necessary.

**Preoperative Surgical Indications Required:**

Preoperative clinical surgical indications for spinal fusion include all of the following: 1) all pain generators are identified and treated, 2) all physical medicine and manual therapy interventions are completed, 3) x-ray, MRI, or CT/discography demonstrating disc pathology or spinal instability, 4) spine pathology limited to two levels, 5) psychosocial screen with confounding issues addressed, 6) for any potential fusion surgery, it is recommended that the injured employee refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing.

The rationale for the opinion stated in this report is based on the review of the above mentioned records, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk  
TDI-Division of Workers' Compensation  
P.O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 17<sup>th</sup> day of July, 2006 from the office of IMED, Inc.

Sincerely,

---

Charles Brawner  
Secretary/General Counsel