



DATE OF REVIEW: February 27, 2008

IRO Case #:

**Description of the services in dispute:**

Items in dispute: Minimally invasive anterior/posterior fusion at L5-S1 with 2 day LOS.

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The physician who provided this review is board certified by the American Osteopathic Board of Surgery in Neurological Surgery. This reviewer is a member of the American Osteopathic Association, the American College of Osteopathic Surgeons, the Texas Osteopathic Medical Association and the Texas Medical Association. This reviewer has been in active practice since 1995.

**Review Outcome**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

**Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.**

The requested minimally invasive anterior/posterior fusion at L5-S1 with 2 day LOS is not medically necessary.

**Information provided to the IRO for review**

1. Utilization review determination dated 01/18/08
2. Utilization review determination dated 02/06/08
3. Medical records Dr.
4. Medical records Dr.
5. MRI of the lumbar spine dated 02/08/07
6. EMG/NCV report of the upper extremities dated 02/22/07
7. Procedure reports
8. Cervical and lumbar myelogram reports dated 07/03/07

9. Lumbar discography report dated 12/27/07
10. CT of the lumbar spine dated 12/27/07
11. Clinical note Dr. dated 01/08/08
12. Lumbar flexion and extension films dated 01/23/08
13. Behavioral assessment dated 01/30/08
14. Carrier correspondence

**Patient clinical history [summary]**

The patient is a male who is reported to have sustained an injury to his low back. The first available medical record is dated 01/02/08. This note indicates that the patient is status post an L5-S1 discogram. He is reported to have had severe concordant pain at L5-S1 with no pain at L2-3, L3-4, and L4-5 with disc stimulation up to 100 psi. He is reported to have some degenerative changes at L4-5 but no pain or complete annular tear. On physical examination the patient shows some dural tension signs on the right but full out to 90 degrees sitting. Neurologically intact in the lower extremities and the wound does not appear to be infected. The patient is diagnosed with L5-S1 discogenic pain with a marked loss of disc height and radicular pain. The patient is to be seen by Dr. for fusion.

**Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.**

The patient was seen by Dr. on 01/17/08. The patient is reported to be status post lumbar discography performed on 12/27/07 with reported concordant pain at the L5-S1 disc. The patient has been seen by a spine surgeon, Dr. who has requested preauthorization for L5-S1 discectomy and fusion. He states that he has had trouble urinating and saw his urologist earlier to rule out infection. He complains of low back and buttock pain radiating down to his legs more on the right now with intermittent tingling in his feet. On physical examination he is reported to be well developed and well nourished and in no acute distress. He is alert and oriented. Lumbar flexion and extension cause back pain. He has bilateral lumbar paraspinal area tenderness. Straight leg raising is positive at 45 degrees bilaterally. Femoral stretch test only causes low back pain bilaterally. The patient is reported to have discogenic low back pain at the L5-S1 level with lumbar radiculopathy and mild lumbar spinal stenosis. This note further indicates that the patient is status post a C4-6 ACDF and is improved. He further is status post a left ulnar nerve transposition and is improved and a left carpal tunnel release and is improved.

The record further includes an MRI of the lumbar spine dated 02/08/07. This study shows a small left L5-S1 foraminal disc protrusion which combined with disc flattening and facet hypertrophy results in moderate to severe left neural foraminal narrowing with mild to moderate right neural foraminal narrowing present as well. Bilateral L3 and L4 neural foraminal narrowing relating predominantly to posterolateral disc bulging and endplate spurs. There is severe T12-L1 and L5-S1

degenerative disc disease. The record includes electrodiagnostic studies of the upper extremities dated 02/22/07 which report evidence of a severe left ulnar neuropathy and a moderate left median neuropathy. The record further includes a lumbar myelogram performed on 07/03/07. This study reports a mild disc bulge with posterior thecal indentation combining to produce mild to moderate central stenosis. At L4-5 there is a similar mild disc bulge with posterior thecal sac indentation producing at least mild central stenosis. There is truncation of the left proximal L5 nerve root sleeve with slight underfilling or edema suggested of the right L5 nerve root sleeve. There is severe disc narrowing and degenerative change with a moderate posterior osteophyte at L5-S1. The post myelogram CT of the lumbar spine indicates there is a 2-3 mm posterolateral disc bulge bilaterally combining with prominent posterior epidural fat to produce mild to moderate central canal stenosis. At L4-5 there is a 3 mm left and a 3-4 mm right posterolateral disc bulge with a right posterolateral osteophyte, facet arthropathy and tropism and mild ligamentum flavum hypertrophy and prominent posterior epidural fat producing moderate central canal stenosis diffusely. At L5-S1 there is severe disc space narrowing and degenerative changes with a 3 mm diffuse combination disc bulge and irregular osteophyte. The patient was seen by Dr. on 11/16/07 and at this time he is reported to be 12 weeks post op a C4-C6 anterior cervical discectomy and fusion. The patient is very pleased with the results from the surgery from cervical standpoint. He continues to have concerns regarding severe low back pain. The patient is reported to be status post 2 epidural steroid injections without any relief. He continues to be on oral narcotics. Dr. recommends that the patient undergo four level lumbar discography.

On 12/27/07 the patient underwent lumbar discography as described above. This study reports a negative L2-3 discogram. At L3-4 there is an incomplete anterior annular tear. At L4-5 there is an incomplete posterior annular tear. At L5-S1 there is a full thickness posterior lateral right annular tear with advanced degenerative disc disease and reported concordant pain. Dr. has recommended that the patient undergo an L5-S1 minimally invasive anterior/posterior fusion for degenerative disc disease and internal derangement. The patient was referred for a behavioral medicine evaluation on 01/30/08. This report indicates that the patient has no limitations regarding spinal surgery. The record indicates the patient was referred for flexion and extension radiographs of the lumbar spine on 01/23/2008. These studies do not indicate any instability of the lumbar spine.

The case has previously been reviewed on 01/18/08 by Dr. Dr. reports that the patient's strength is normal bilaterally. Sensory is grossly normal. Reflexes are 2+ throughout. He discusses the imaging studies and opines that there is no evidence of instability or spondylolisthesis and based on the patient's history as well as discussion with Dr. 's PAC, the request for anterior posterior fusion is not medically necessary. The case was subsequently reviewed by Dr. on 02/06/08. Dr. notes that the patient is status post ACDF with continued low back pain. He notes that the patient is neurologically intact. He notes that there is severe disc space narrowing. He discusses the concordant pain at L5-S1 and notes that the patient has a psychiatric evaluation. Dr. apparently

spoke with Dr. and opines that operative intervention is not medically necessary. He notes that the patient continues to complain of severe low back pain but denies leg pain. He notes that there is disc space narrowing at L5-S1 with a positive discogram. He again notes that the record does not include flexion and extension films and there is no evidence of instability or spondylolisthesis. He opines that operative intervention consisting of an anterior/posterior fusion at L5-S1 is not indicated as medically necessary.

Items in dispute: Minimally invasive anterior/posterior fusion at L5-S1 with 2 day LOS.

This reviewer concurs with the previous reviewers. The available medical record indicates that the patient has a history of low back pain and has clear evidence of degenerative disc disease at L5-S1. The patient has undergone lumbar discography which is reported to be positive at the L5-S1 level. There are noted degenerative changes at L3-4 and L4-5. The records do not provide detail regarding whether or not the patient has undergone preoperative physical therapy. He is noted to have undergone 2 epidural steroid injections with no improvement; however, based on the available records, the patient does not appear to have a lower extremity radiculopathy. The record includes flexion/extension views to establish that the patient has no instability. Imaging studies suggest stenosis at multiple levels which may potentially benefit from decompression; however, given the lack of instability on extension and flexion films fusion does not appear to be medically necessary.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

1. Official Disability Guidelines, Return To Work Guidelines (2007 Official Disability Guidelines, 12th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition) Accessed Online