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Notice of Independent Review Decision

DATE OF REVIEW: June 11, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Removal of pedicle screws, exploration of fusion, and bone graft to fusion.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow American Academy of Orthopedic Surgeons

REVIEW OUTCOME

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

☒ Upheld (Agree)

Medical documentation does not support the medical necessity of removal of pedicle screws, exploration of fusion, and bone graft to fusion.

ODG have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a who was lifting a heavy machine when he slipped and fell and injured his back.

Magnetic resonance imaging (MRI) of the lumbar spine in 2006 revealed: (1) intervertebral osteochondrosis of L5-S1 with active dorsal annular bulge showing a focal annular tear effacing the right S1 nerve root. (2) Facet hypertrophy with imbrication of L5-S1 encroaching on the neural foramen. (3) A 4 mm right far lateral disc protrusion (subligamentous herniation) at L4-L5 compressing the exiting right L4 dorsal root ganglion. (4) Intervertebral osteochondrosis at L3-L4 with anterolateral spondylosis and Modic type II reactive endplate marrow changes.

The patient was treated with medications (oxaprozin, cyclobenzaprine, and ibuprofen), and lumbar epidural steroid injection (ESI) x3.

In a required medical evaluation (RME), M.D., rendered the following opinions: (1) The compensable diagnosis and extent of injury was herniated disc at L4-L5

and L5-S1. (2) Osteochondrosis was a mild and pre-existing degenerative condition. (3) Chiropractic treatment was no longer indicated. (4) The patient should undergo CT/myelogram. A lumbar discogram was totally contraindicated. He was a candidate for laminectomy at L4-L5 and L5-S1. (4) Narcotic analgesics, non-steroidal anti-inflammatory drugs (NSAIDs), and antidepressants might be helpful. (5) He was capable of working at sedentary level.

A lumbar discogram was positive for concordant pain at L3-L4, L4-L5, and L5-S1 disc levels. Post discogram CT revealed: (1) Right paracentral posterior annular tear at L5-S1 resulting in small degree effacement of the thecal sac anteriorly. (2) Posterior fissuring at L4-L5 and small degree of lateral recess narrowing. (3) Diffuse fissuring at L3-L4 with small degree of lateral recess narrowing.

On April 10, 2007, M.D., performed discectomy and 360 degree fusion at L3-L4, L4-L5, and L5-S1 with instrumentation and bone growth stimulator placement. Following the surgery, the patient had urinary retention and scrotal swelling, which turned out to be a urinary tract infection (UTI). He had burning into his thighs and numbness in feet as well as diminished sensation in both thighs and generalized motor weakness. He was using a walker for ambulation. X-rays revealed good position of the hardware. In July 2007, Dr. reexamined the patient and opined as: He was not at maximum medical improvement (MMI). (2) He should undergo PT of lumbar spine. (3) Sustained release narcotics, Neurontin/Lyrica, and antidepressants would be reasonable.

Lumbar myelogram/CT revealed: (1) Extensive post surgical changes with bilateral transpedicular screws and bilateral fixation rods extending from L3 through S1. Minimal L5-S1 disc space narrowing with moderate posterior spondylosis. Mild L1-L2 and L2-L3 disc space narrowing. (2) Posterior central and minimally to left focal disc protrusion or disc herniation with some mass effect along the anterior aspect of the thecal sac at L5-S1. Moderate right and mild-to-moderate left L5-S1 facet arthrosis. Moderate to severe left and moderate right L5-S1 neural foraminal encroachment predominantly related to osteophytic lipping as well as posterolateral disc bulge. (3) Moderate L4-L5circumferential disc bulge or disc protrusion with mild mass effect along the anterior aspect of the thecal sac as well as mild central stenosis and construction of the thecal sac. Moderate bilateral L4-L5 neural foraminal stenosis related to degenerative factors. (4) Impingement of the exiting L5 nerve roots bilaterally more prominent on the left and to a lesser degree of the exiting L4 nerve root related to degenerative factors. (5) Mild L1-L2 and L2-L3 disc bulge. Mild L2-L3 and mild-to-moderate L3-L4 thecal sac constriction and central stenosis.

In a chronic pain evaluation, the patient was diagnosed with chronic pain, psychological factors secondary to chronic pain, sleep disorder secondary to chronic pain, and generalized pain disorder. A functional restorative program was recommended. Dr. stated that there was a good radiographic result from the surgery, but a poor clinical outcome. He recommended no additional interventional treatment. In a second surgical opinion, M.D., opined as: Besides mild loosening at the Alar Screws bilaterally, there was no radiographic evidence of infection. There was no acute need for additional surgery. Although, he was not fused radiographically on the post-myelogram CT prints, he was only 4.5 months postoperatively. Additionally surgery should be entertained if there was a pseudoarthrosis. Although, the lateral screws at L4 could be a pain generator for

him, it was not likely the sole or major cause of his symptoms. Bilateral L3 selective nerve root blocks could be very beneficial in helping to determine just how much of his pain was due to these screw positions.

Electromyography/nerve conduction velocity (EMG/NCV) study revealed mild chronic residual lumbosacral radiculopathy at L5-S1 on the right. Dr. opined that he could consider hardware removal when this fusion was solid.

In January, M.D., a designated doctor, opined as follows: (1) Diagnosis was probable fissure of fusion and recurrent herniated nucleus pulposus (HNP). (2) The patient's medical condition resulting from the injury had prevented and was still preventing him from returning to work as of January 23, 2008, and was expected to continue through April 23, 2008. (3) The patient's medical condition was a direct result of the work-related injury. (4) He had not reached MMI and was expected to do on or about April 23, 2008. In April 2008, Dr. noted that the hardware was well-positioned and there was a good fusion mass anteriorly. He diagnosed painful hardware and recommended clearance from a gastroenterologist (for rectal bleeding), a urologist, and general medicine prior to hardware removal surgery.

M.D., a designated doctor, rendered the following opinions: (1) The patient was not at MMI. (2) He was not able to return to work in his present condition. (3) He had post laminectomy pain likely related to scar tissue and atrophy from L2 through S1 of the erectus spinal muscles. He would need a psychiatric evaluation (for postoperative depression), urology evaluation (for frequency, lack of sexual drive, and erection), and infectious disease (to establish cause of the fever). (4) His disability was related to his most recent intervention on April 10, 2007. It would be helpful to determine that the extensive fusion had healed properly through radiological test. Then, it should be determined if the removal of the hardware could be helpful in his recovery.

On April 29, 2008, the request for the hardware removal was non-authorized with the following rationale: "*There has been no recent CT scan performed to see whether or not the fusion is indeed solid and it is reasonable to take out the hardware. There is no evidence of motion segment instability documented in the records, no evidence of progressive neurologic deficit documented, and no documentation of a diagnostic potentially therapeutic cortisone or lidocaine injection test to see if painful hardware would give relief of symptomatology. It appears that he has multiple comorbidities. There is no documentation of conservative measures recently in the form of formal activity modification or anti-inflammatory medications.*"

M.D., assessed severe major depressive disorder with psychotic features, suicidal ideation, and homicidal ideation aggravated and worsened by opioid dependency, chronic severe pain disorder, and opioid dependency. He recommended individual and group psychotherapy, biofeedback training, and psychological testing.

On May 12, 2008, an appeal for the hardware removal surgery was non-authorized with the following rationale: "*The requesting physician has failed to demonstrate instability which would lead to repeat fusion. Based on the clinical information submitted for this review and using the evidenced-based, peer*

reviewed guidelines referenced above, the request is not indicated."

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

The requested procedure is exploration of a spine fusion from L3 to S1 with removal of hardware and bone grafting. According the patient's clinical history there has been no recent CT scan demonstrating a pseudarthrosis or need to explore the fusion. There also has been no injection done at the hardware to determine whether this would relieve the patient's symptoms if it were removed. There is also a psychological evaluation by Dr. dated May 12, 2008, which mentions major psychiatric issues. The patient also has multiple comorbidities. This opinion agrees for the most part with the opinion of M.D.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**