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Notice of Independent Review Decision

DATE OF REVIEW: 09/08/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Posterior spinal fusion at L4-L5 with TLIF and inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

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. MRI of the lumbar spine dated 02/06/08
2. MRI of the lumbar spine partial report dated 05/21/08
3. Medical records, , M.D., dated 06/25/08 thru 07/09/08
4. CT of the lumbar spine dated 07/02/08
5. Report of discography dated 07/02/08
6. Physical therapy records dated 07/08/08 thru 08/11/08
7. Utilization Review Determination dated 07/22/08
8. Utilization Review Determination dated 08/07/08
9. Letter of Appeal, dated 08/13/08
10. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was described as a xx year old female who was reported to have sustained an injury to her low back as a result of lifting a patient on xx/xx/xx.
The employee is currently under the care of , M.D.

The first available clinical record was an MRI of the lumbar spine performed on 02/06/08. The employee was reported to have a history of lower back pain radiating into the right leg with weakness. The employee previously had a CT myelogram performed on 01/31/06. This study reported mild spondylitic disc bulges at L2-L3 through L5-S1 without compromise of the canal or exiting foramina. There was no stenosis or impingement, particularly on the right side, and no focal herniation. The exit foramina at L4-L5 and L5-S1 were mildly encroached on the inferior aspects due to the margins of the disc bulge. There was a small subcentimeter synovial cyst projecting posterior to the right L5-S1 facet. MRI finding were reported to correlate with CT myelographic findings.

Records indicate that the employee underwent a second MRI of the lumbar spine performed on 05/21/08. The full report was not available but page two of two was contained in the records. This study reported multilevel spondyloarthropathy which may result in clinically significant relationships. The radiologist refered to the body of the report for comprehensive segmental analysis.

On 06/25/08, the employee was evaluated by Dr. . At that time, the employee reported low back pain and left lower extremity radiculopathy beginning on 05/15/08 when she was working in a yard planting something and she bent over. She reported she was not able to stand up straight after that time. Since then, the employee has leaned over in flexion, walked with a cane, and used a wheelchair to get around. She reported that the pain was intolerable and constant.

The employee was reported to have seen Dr. for pain management and received two sets of epidural steroid injections, the last one on the previous Monday. The employee reported that the first one helped with some improvement but the second did not help at all. She had received a Medrol Dosepak from the emergency room physician after she presented. She reported pain in her lower back, buttocks, groin area, the front of her calf down the lateral side of the calf, as well as in the bottom of her foot on the left side. Her left leg pain was worse than her back pain. She was reported to be frustrated. The employee's past medical history was significant for asthma, fibromyalgia, phlebitis, TIA x 2, hypertension, kidney stones, migraines, thyroid disease, anemia, and antiphospholipid adrenal insufficiency. The employee's past surgical history was positive for a left total knee replacement in 2007. Upon physical examination, the employee was 5 feet 2 inches tall and weighed 158 pounds. She had an antalgic gait. She had difficulty with heel/toe walking. She had severely decreased lumbar extension which caused a lot of pain. She had somewhat decreased lumbar flexion with only minimal pain. She was actually in the position where she was flexed over during walking. There was tenderness to palpation of the lumbar as well as the surrounding paraspinous musculature. She has left sciatic notch tenderness. Babinski's was down going. Straight leg raise was positive on the left. There was decreased sensation in left L4 and L5 distributions. Reflexes on the left side were trace at the knee and 1+ at the ankle. The employee had previously undergone a left total knee replacement. On the right side, reflexes were 2+ at the knee and ankle. On the right side, the employee had 2+ deep tendon reflexes at the knee and ankle. Motor

strength testing revealed mild weakness in the tibialis anterior and right EHL. On the left, the employee was 4-/5 in the left tibialis anterior and a 5-/5 in the left gastroc and 4-/5 in the left EHL. Radiographs were reported to indicate lumbar spondylitic disease at L4-L5 with significant decrease in disc height. The employee was reported to have severe axial back pain and radiculopathy which was reported to be 50-50. She was reported to have received multiple epidural steroid injections as well as physical therapy without any relief of the pain. It was recommended that the employee undergo lumbar discography from L2-L3 through L5-S1.

The employee was referred for lumbar discography on 07/02/08. This study reported a circumferential Grade VI annular fissuring at L4-L5. There was no associated generalized disc bulge. There appeared to be a superimposed left subarticular disc protrusion measuring 3 mm to 4 mm in AP extent. This was in close proximity to the exiting left L4 nerve root. This may correlate with a left L4 radiculopathy. There was a partial circumferential Grade IV annular fissuring at L2-L3 and L3-L4. There was generalized disc bulging at both levels with no significant central canal or foraminal stenosis. The nuclear morphology at L5-S1 appeared to be normal. The report of discography suggested concordant pain at L2-L3 and L4-L5. L3-L4 was reported to have been 0/10 and nonconcordant. L5-S1 was reported to be nonconcordant with pain levels of 6/10. This note regarding discography did not include opening and closing pressures.

The employee was seen in follow-up on 07/09/08. She was reported to have undergone recent discogram which revealed concordant pain at L2-L3 and L4-L5 with an annular tear extending out to L4-L5. Dr. opined that the employee had significant axial back pain and weakness in her bilateral lower extremities. Her symptoms were concordant with an L4-L5 discography as well as MRI. Dr. subsequently recommended that the employee undergo an L4-L5 posterior spinal fusion with TLIF in light of her significant radicular symptoms.

On 07/22/08, the case was reviewed by Dr. . Dr. noncertified the request. He reported that the requesting physician had failed to demonstrate the presence of lumbar instability. As a result, Dr. found the procedure noncertified.

This decision was appealed, and on 08/07/08, the case was reviewed by Dr. . Dr. noncertified the request. Dr. noted that all pain generators had not been assessed, and the employee had not undergone psychosocial screening. In the absence of these records, Dr. found the request to be noncertified.

The record contains a letter of appeal dated 08/13/08. At that time, it was reported that the employee sustained an injury to her low back as a result of lifting a patient up during a code on 05/12/08.

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

I would concur with the two previous reviewers in that the requested procedure is not supported by the submitted clinical information and does not appear to be medically necessary. The records only included a partial MRI report dated 05/21/08. The employee was reported to have low back pain with radiation into the left lower extremity. Previous imaging studies indicate that the employee had low back pain with radiation into the right lower extremity. Records report that the employee has undergone two sets of epidural steroid injections; however, the procedure reports were not included. The employee was later referred for lumbar discography on 07/02/08. It would be noted that the submitted report of discography did not include opening and closing pressures which would invalidate this study. The employee was reported to have a negative controlled disc at L3-L4 with concordant pain at L2-L3 and L4-L5 and nonconcordant low back pain at L5-S1. The submitted clinical records did not include any flexion and extension views of the lumbar spine to establish instability.

Based upon the lack of clinical information regarding instability and the lack of a required psychosocial evaluation, the requested procedure is not medically necessary or supported by current evidence-based guidelines.

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

1. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.
2. Deyo RA, Nachemson A, Mirza SK, Spinal-fusion surgery - the case for restraint, N Engl J Med. 2004 Feb 12;350(7):722-6
3. Gibson JN, Waddell G. Surgery for degenerative lumbar spondylosis: updated Cochrane Review. *Spine*. 2005 Oct 15;30(20):2312-20.
4. Atlas SJ, Delitto A. Spinal Stenosis: Surgical versus Nonsurgical Treatment. Clin Orthop Relat Res. 2006 Feb;443:198-207.
5. Resnick DK, Choudhri TF, Dailey AT, Groff MW, Khoo L, Matz PG, Mummaneni P, Watters WC 3rd, Wang J, Walters BC, Hadley MN; American Association of Neurological Surgeons/Congress of Neurological Surgeons. Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 7: intractable low-back pain without stenosis or spondylolisthesis. J Neurosurg Spine. 2005 Jun;2(6):670-2.