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Notice of Independent Review Decision

DATE OF REVIEW: 07/21/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Anterior lumbar interbody fusion (ALIF) L4-5, L5-S1; Laminectomy L4-S1; Posterior instrumentation @ L4-S1 with 4-day inpatient stay.
DME back brace

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.83	22612	Upheld
		Prospective	722.83	22840	Upheld
		Prospective	722.83	63047	Upheld
		Prospective	722.83	63048	Upheld
		Prospective	722.83	22558	Upheld
		Prospective	722.83	63090	Upheld
		Prospective	722.83	22851	Upheld
		Prospective	722.83	76000	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician/practitioner notes from 07/06/07 through 07/20/09

MRI of the lumbar spine dated 11/04/08

EMG/NCV study of the lower extremities dated 11/07/08

CT myelogram of the lumbar spine dated 04/21/09

Radiographic report lumbar spine dated 04/21/09, 12/19/08

Official Disability Guidelines cited but not provided

PATIENT CLINICAL HISTORY:

The male is reported to have sustained an injury to his low back on xx/xx/xx, while lifting a pipe weighing approximately 300 pounds. He developed significant low back pain with radiation into the lower extremity. An MRI of the lumbar spine dated 11/04/08 showed normal disc architecture and structure at L1-2 and L2-3. At L3-4 there is facet hypertrophy but the central canal and neural foramen are widely patent. At L4-5 there is a broad based annular protrusion with posterior disc enhancement. Facet hypertrophy is apparent and the neural foramen are small but appear to be sufficient in size to accommodate the nerve roots. At L5-S1 there is facet hypertrophy which appears to be a broad based annular protrusion as well as a posterior enhancement of the disc margin. The central canal is without significant stenosis and the neural foramen are open. EMG/NCV studies of 11/07/08 showed a distal left and bilateral L5 mildly chronic radiculopathy. On 11/17/08 the patient underwent caudal epidural steroid injection without significant improvement.

At an evaluation visit dated 12/05/08, the history reports “the patient was status-post lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L4-5 on the right performed on 08/20/08. The patient presented with an aggravation of his previous symptomology and low back pain with radiation to the bilateral lower extremities, left greater than right.” Examination reported lumbar range of motion to be decreased in forward flexion secondary to muscle spasms. Motor strength was graded as 5/5, and DTRs were 2+ throughout and symmetric. Gait was antalgic. The patient had slight difficulty with toe and heel walking and less difficulty with tandem walk. Straight leg raise test was reported to be positive bilaterally at 50 degrees. Sensory examination was reported to show a hypoesthetic region in the L5 and S1 distributions on the left. The clinical impression was “post laminectomy syndrome status-post microdiscectomy, lumbar mechanical discogenic pain syndrome at L4-5 and L5-S1, lumbar radiculitis, and lumbago.” The recommendations included a CT discogram.

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At a different evaluation visit dated 12/19/08, the above history was noted. In addition, it was reported that the patient had been treated with physical therapy, epidural steroid injections, pain medications, anti-inflammatories as well as a laminectomy procedure. On 12/19/08 the patient reports pain with any activity. He was taking anti-inflammatory and pain medications. Physical examination showed the patient's difficulty getting up on his toes and heels. He has reduced lumbar range of motion. Left EHL dorsiflexors and plantar flexors are graded as 4/5. Right EHL dorsiflexors and plantar flexors are graded as 4+/5. Straight leg raise is reported to be positive at 45 degrees and DTRs are 2+ at the patella and Achilles. The patient has decreased sensation on the dorsum as well as the lateral aspect of the foot on the left. The clinical assessment indicated the patient was a candidate for 2 level fusion from L4-S1 with posterior 2 level 360-degree fusion with posterior instrumentation.

The patient was seen in follow up on 03/20/09. He continues to have low back pain with bilateral lower extremity pain. He is reported to be in significant distress. His motor strength is unchanged. DTRs are diminished at the patella and Achilles' tendons, and the patient continues to have decreased sensation in the dorsum and lateral aspects of the foot. A CT myelogram is recommended.

On 04/21/09 the patient underwent a CT myelogram. This study reports disc space narrowing at L4-5 and L5-S1 with mild vacuum in the L5-S1 disc space. There is no disruption, herniation or stenosis identified at L1-2, L2-3 and L3-4. There is no current canal or foraminal stenosis at any of these levels. At L4-5 there is a minimal broad-based disc protrusion. There is no definite canal or foraminal stenosis. At L5-S1 there is a minimal disc protrusion with no canal or foraminal stenosis. On this same date the patient underwent lumbar radiographs, including flexion and extension views, which showed mild degenerative disc changes at L4-5 with no evidence of subluxation on flexion or extension. There is mild osteophyte formation at L5-S1 and prominent osteophyte formation at L4-5.

At an IME visit dated 04/27/09, it was noted that the patient's past medical history is significant for depression and obesity. The patient's past surgical history includes arthroscopy to the right knee, left knee surgeries x3, appendectomy, microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L4-5 on the right performed on 08/20/08, and amputation of the left thumb. It is noted that the patient has received extensive conservative treatment including epidural steroid injections. It was also noted that lumbar myelogram revealed degenerative disc narrowing at L4-5 with a mild annular protrusion eccentric to the right at L5-S1. The myelographic films revealed no extradural or intradural defect, and the nerve root sleeves appeared to fill normally. This was reported to be disc herniations at L4-5 and L5-S1. Physical examination showed the patient to be 6'1" tall and weighs 260 pounds. (The patient is reported to be obese.) He had no evidence of scoliosis or kyphosis. He had a non antalgic gait but diminished

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stride length. He was able to walk on his heels and toes but complained of low back pain. He was able to perform 3 bilateral heel raises and 2 unilateral heel raises bilaterally. He is reported to be unable to squat and stand from a low lying stool complaining of severe pain. He had diffuse tenderness with palpation of the lumbar paraspinal muscles. There were no trigger points or spasms noted. Straight leg raise was 90 degrees bilaterally with supine straight leg raise at 16 degrees on the right and 20 degrees on the left. This is reported to have caused severe low back pain. Hoover's test was positive. Sensation to pinprick and light touch was intact in the lower limbs. DTRs were 2+ and symmetric at the knees and ankles and there was no clonus present. Lumbar range of motion was markedly reduced. Manual muscle strength testing of the lower extremities is reported to be invalid due to giving away. The patient was able to perform heel raises and toe raises, on manual muscle strength testing in the supine position he provided virtually no effort and complained of severe pain when testing the ankle, foot, knee and hip. There is no evidence of atrophy. Waddell's testing was positive for axial load. Rotation, straight leg raising and subjective complaints are out of proportion with objective findings. The patient was assessed as reaching MMI: The patient's recent MRI and CT myelogram provide no documentation of a surgical lesion and no evidence of intersegmental instability.

At a different 05/22/09 evaluation visit, the patient reports having back and leg pain; a laminectomy had been performed with no improvement, and after surgery his left leg is noted to be more painful. He has pain in the right leg in a similar distribution. He had physical therapy before and after surgery, approximately 12-15 sessions, with no improvement. He had post-operative epidural steroid injections with no improvement. He has severe sitting and standing intolerance due to severe pain. Physical examination showed the patient to be 6'1" tall and weigh 270 pounds. He has an abnormal, slow, forward flexed gait. The patient is reported to have an inability to walk secondary to gastroc soleus weakness. The patient has severe pain with forward flexion and extension and severe limited range of motion. Extension, rotation and side bending is 5-10 degrees. There is severe tenderness to palpation of the bilateral paraspinous region and bilateral sciatic notch. He has a scar on the right side of midline, and he is reported to have positive Cram, positive straight leg raise and positive Lasegue's test bilaterally. Reflexes are 1+ at the patella on the right and 2+ on the left and 2+ Achilles on the right and absent on the left. Sensory testing to light touch is decreased on the right lateral shin and left lateral thigh. There is no ankle clonus and negative Babinski. The patient is reported to have 5/5 strength in the hip flexors, leg extensors, leg flexion, tibialis anterior EHL bilaterally and severe weakness with plantar flexion with gastroc soleus testing graded as 3-4/5 bilaterally. An anterior lumbar interbody fusion at L4-5 and L5-S1 along with decompression at L4-5 and L5-S1 with posterior instrumentation procedure was recommended. In addition, another different evaluation dated 5/30/09 found the patient not to be at MMI. On 7/20/09 the patient presented for followup and was diagnosed with post-laminectomy syndrome.

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

In the Reviewer's opinion, the request for anterior lumbar interbody fusion from L4-S1 with decompression and posterior instrumentation, 4-day inpatient stay, and DME is not supported by the submitted clinical information. The available medical records indicate that the patient initially sustained an injury to his low back as a result of lifting a pipe. The patient subsequently received extensive conservative treatment and ultimately was taken to surgery and underwent an L4-5 laminectomy with discectomy on 08/20/08. Post-operatively the patient reported no improvement in his condition.

The patient was subsequently referred for MRI of the lumbar spine on 11/04/08. This study indicates a broad based disc protrusion at L4-5 without evidence of central canal stenosis or neural foraminal stenosis. At L5-S1 there is a similar disc protrusion without significant central canal stenosis and the neural foramen are patent. In the opinion of the Reviewer, this study does not indicate any neural compressive lesions. The patient was later referred for EMG/NCV study on 11/07/08. This study reports chronic distal left and bilateral L5 radicular findings; however, according to the Reviewer, this is a post-operative study, and there is no evidence of acute changes. These results most likely represent residuals from the previous surgery.

The Reviewer noted that the physical examinations documented by several physicians were inconsistent. The patient was referred for CT myelogram on 04/21/09, and according to the Reviewer, there is no evidence of canal or foraminal stenosis at both the L4-5 and L5-S1 levels. Also, the Reviewer indicated there is no noted instability on lumbar flexion and extension radiographs of 04/21/09.

An IME report dated 04/27/09 indicates that the patient has intact motor strength with inconsistent behavior on examination: It is noted that the patient is capable of performing bilateral heel raises with increased back pain, yet when tested in the supine position the patient provided no effort. The patient's reflexes are reported to be 2+ and symmetric and the seated straight leg raise was 90 degrees bilaterally, but on supine testing this was only 16 degrees on the right and 20 degrees on the left, which indicate an inconsistency. It was further reported that the patient's sensation to pinprick and light touch is intact, but there is no evidence of atrophy in the lower extremities, and the patient exhibits 4+ Waddell's signs. However, an examination by a different practitioner approximately one month later showed significant differences.

In summary, in the opinion of the Reviewer, based on current evidence-based guidelines, the patient is not a candidate for fusion. It is noted that the patient does not have any neural compressive lesions identified on imaging studies. The patient has no instability of the lumbar spine. There are clearly significant differences on physical examination. The IME finds no evidence of neural compressive lesions, and the patient

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is noted to have positive Waddell's signs. The patient has not been referred pre-operatively for a psychiatric evaluation. Therefore, given the totality of the information, the patient is not a candidate for fusion.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**