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Notice of Independent Review Decision

AMENDED: March 20, 2009
AMENDED #2: March 25, 2009

DATE OF REVIEW: March 11, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Anterior lumbar interbody fusion @ L5-S1 with posterior lateral fusion with percutaneous instrumentation and inpatient stay x 3 days.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

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 the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
TDI

- Utilization reviews (01/14/09, 01/23/09)

- Office notes (09/27/07 – 02/10/09)
- Diagnostics (08/08/08)
- Psychological evaluation (12/02/08)

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ODG Criteria have been used for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was lifting a heavy box and attempting to put it on a shelf when he experienced back pain, leg weakness, and fell to the floor.

Initially, the patient was treated with medications including Flexeril, hydrocodone, and naproxen and physical therapy (PT). In August, magnetic resonance imaging (MRI) of the lumbar spine demonstrated a 3-mm central to left parasagittal soft tissue disc protrusion at L5-S1 extending into the anterior prethecal epidural space at the level of the S1 nerve root sleeve and a 1-2-mm annular bulge at L3-L4.

M.D., evaluated the patient for constant low pain radiating to the right nerve root and right anterior thigh numbness. On examination, there was tenderness on lower back bilaterally and decreased lumbar range of motion (ROM). X-rays of the lumbar spine were unremarkable. Dr. assessed lumbar sprain/strain and L5-S1 disc protrusion, prescribed Medrol Dosepak, and recommended PT with active and passive ROM and strength/endurance training. The patient was treated with an epidural steroid injection (ESI) x1, with no relief of symptoms. He returned to work with restrictions.

Electromyography/nerve conduction velocity (EMG/NCV) study demonstrated left L5 radiculopathy. As there was no improvement in the symptoms of the patient, Dr. decided to perform anterior lumbar interbody fusion (ALIF) at L5-S1 with instrumentation, posterior lateral fusion with percutaneous instrumentation. However, the surgery was denied twice.

In December 2008, the patient underwent a psychological evaluation. It was noted that in the DDE he was placed at maximum medical improvement (MMI). He was diagnosed with adjustment disorders with depressed mood. Psychologically, the patient was cleared for surgery and was recommended to stop smoking and to review effectiveness of sleep medication.

On January 14, 2009, request for anterior lumbar interbody fusion (ALIF) at L5-S1 with posterior lateral fusion with percutaneous instrumentation and inpatient stay x3 days was denied with the following rationale: *The patient has ongoing complaints of back as well as bilateral leg pain. The patient had a psychosocial assessment on December 2, 2008. He was to sustain from smoking and was judged to be cleared for surgery. There is insufficient information to approve the fusion, single level. There is no documentation of instability. The pain generators were not localized. There is no documented progressive neurologic deficit. This recommendation is in accordance with ODG Guidelines.*

On January 23, 2009, appeal for the lumbar surgery was denied with the following rationale: *For chronic low back problems, fusion should not be considered within the first six months of symptoms, except for fracture, dislocation, or progressive neurologic loss, indications for spinal fusion may include: (1) Neural arch defect – spondylolytic spondylolisthesis, congenital*

neural arch hypoplasia. (2) Segmental instability (objectively demonstrable) – excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability, and mechanical invertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Under current guidelines the use of fusion is not recommended in the absence of spinal instability. Records do not reflect this patient has spinal instability.

On February 10, 2009, Dr. noted complaints of bilateral lower back and leg pain, lumbar pain radiating into bilateral buttocks, anterior thigh, lateral thigh, posterior thigh, posterior knee, shin, and pedial aspect of the foot. The patient stated left side was worse than the right. He was taking Trazodone, Vicodin, and baclofen. Examination of the low back revealed positive straight leg raise (SLR) with pain radiating to the left posterior thigh and posterior calf and decreased sensation to light touch to entire right at L5. X-rays of the lumbar spine revealed positive instability at L5-S1 of 5-mm. Dr. recommended anterior lumbar fusion and posterior lumbar fusion through minimally invasive route at L5-S1 based on following reasons: The patient had failed conservative treatment and continued to have significant back and leg pain, positive SLR on the left, decreased sensation on the right along the L5 dermatomes, positive EMG/NCV study, and positive x-ray and MRI findings.

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

Medical material reviewed:

1. Clinical summary
2. Lumbar MRI report, 8/10/2007, by, M.D.
3. 9/6/2007 report by M.D., with follow up reports by the same doctor through 2/10/2009
4. notes
5. Electrodiagnostic testing, 4/2/2008
6. Psychological evaluation report, 12/2/2008, Ph.D.
7. notification of determination reports of 1/14/2009 and 1/23/2009

This case involves that of a now male who on xx/xx/xx, was lifting over his head and fell in a twisting motion. He developed low back pain which soon extended into both lower extremities primarily initially on the right side but now primarily into the left lower extremity. Examination revealed straight leg raise to be positive primarily on the left side and there is some question of light touch deficit in the L5 distribution on the left side. The patient has had physical therapy, medications, rest and an epidural steroid injection on one occasion on March 22, 2008, but continues with pain in his low back and lower extremities primarily into the left lower extremity. Imaging studies included an August 10, 2007, lumbar MRI which showed significant chronic degenerative disc disease change at L5-S1 but nothing to suggest a lateral disc herniation that might be causing L5 nerve root compression. In addition, it is reported by Dr. that flexion extension views show a 5 mm instability at the L5-S1 level, but I do not have the x-ray report available for review. Electrodiagnostic studies have shown a left L5 radiculopathy. It is of significance to note that the left Achilles reflex is absent.

I agree with the denial for the proposed operative procedure of anterior interbody fusion at the L5-S1 level followed by apparent decompression and posterolateral fusion. The only MRI that I see a report on was done when the patient was having low back and primarily right lower extremity pain and since that time the pain has become more severe on the left side and an EMG shows left L5 radiculopathy. There is nothing on the imaging study to indicate a lateral disc herniation at L5-S1 which might be causing L5 nerve root compression and with the patient having new symptomatology in regard to lateralization and in addition an EMG positive at the L5 level, I think more needs to be done before determining that the L5-S1 level is the only level involved.

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

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**