

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – WC

November 12, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-L5 trans-bilateral interbody fusion, L4-L5 spinal monitoring, and three day 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 determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Utilization reviews (09/24/12 – 10/18/12)
- Diagnostics (05/07/10 - 09/05/12)
- Office visits (02/27/12 - 10/09/12)
- PT discharge summary (04/17/12)
- Utilization reviews (09/24/12 – 10/18/12)

- Diagnostics (05/07/10 - 09/05/12)
- Office visits (02/27/12 - 10/09/12)
- PT discharge summary (04/17/12)
- Utilization reviews (10/18/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured on xx/xx/xx at work. She was packing boxes off when she put a pallet down and felt her back pop. She had severe pain that caused her to fall to her knees.

Pre-Injury Records: On May 7, 2010, the patient underwent a lumbar myelogram and computerized tomography (CT) that showed annular bulging demonstrated at L4-L5 without laceration or stenosis.

Post-Injury Records

On February 20, 2012, magnetic resonance imaging (MRI) of the lumbar spine showed no significant appearing abnormality. There was questionable minimal focal lateral bulging and a questionable left L4 radiculopathy.

On February 27, 2012, , evaluated the patient for back and left leg numbness and tingling. The patient stated that she was already doing light duty. However, she could not perform the duties of picking up boxes. She had not had injections or therapy. reviewed the MRI findings and diagnosed back and leg pain, rule out left L4-L5 foraminal disc herniation with nerve root compression; prescribed hydrocodone, Flexeril and naproxen, recommended starting physical therapy (PT) at Huguley Hospital and considering epidural steroid injection (ESI) based on electromyography (EMG).

On March 26, 2012, noted the patient continued to have back and bilateral leg pain with numbness and tingling. The patient stated that she limped now. She stated that therapy hurt her. She was off work presently due to her increased symptoms of back and leg pain. Examination of the lumbar spine showed positive straight leg raise (SLR) on the left. prescribed hydrocodone, Flexeril and naproxen and recommended ESI based on EMG as the patient continues to complain of radicular pain and had asymmetrical reflexes and a positive SLR.

Per the PT discharge summary dated April 17, 2012, the patient attended 10 sessions of therapy consisting of therapeutic exercises, manual therapy, aquatic exercise, hot pack and electrical stimulation.

On April 30, 2012, noted the patient continued to have back and bilateral leg pain with numbness and tingling. She had gone back to work on a light duty job, but she did not do light duty. prescribed hydrocodone, Flexeril and naproxen and recommended ESI based on EMG and to discontinue therapy as it had not helped her.

On May 31, 2012, performed electromyography/nerve conduction velocity (EMG/NCV) study that showed evidence of a left L4-L5 radiculopathy which was both acute and chronic in nature. There was no evidence of right lower extremity radiculopathy, diffuse peripheral neuropathy, and myopathy or lumbosacral plexopathy.

On August 21, 2012, noted the patient had the ESI but it had not helped. opined that the patient would be a candidate for surgery but would require a CT myelogram for surgical planning. recommended continuing medications, obtaining a CT myelogram for surgical planning and considering L4-L5 and L5-S1 transforaminal lumbar interbody fusion (TLIF).

On September 5, 2012, the patient underwent a lumbar myelogram and CT scan that showed: At L4-L5, the disc was mildly narrowed and there was disc protrusion including a diffuse 2-mm central protrusion and a focal left foraminal 4-mm disc herniation which might be significant if there was a left L4 radiculopathy. There was also slight bulging into the right foramen at this level. Anterolisthesis of about 2-mm in flexion and retrolisthesis of about 2 mm in extension raised the question of instability at this level. There was bilateral mild facet joint spurring and flaval prominence at L4-L5 without central stenosis. There was 1-2 mm right paracentral disc protrusion at L5-S1 indenting the dural sac at and just above the origins of the S1 root sleeves producing minimal ventral dural deformity without root sleeve displacement or underfilling.

On September 18, 2012, noted the patient had non operative treatments including injections and therapy and she was now a candidate for surgery. He recommended continuing medications and requested L4-L5 TLIF with pedicle screw fixation (PSF).

Per the utilization review dated September 24, 2012, the request for L4-L5 trans-bilateral interbody fusion, L4-L5 spinal monitoring three-day inpatient stay was denied based on the following rationale: *"The guidelines state the criteria for lumbar spine fusion includes cases of neural arch defect such as spondylolytic spondylolisthesis or congenital neural arch hypoplasia, or segmental instability relative angular motion greater than 20 degrees. It is noted that minimal dynamic spondylolisthesis occurred on CT myelogram lumbar spine of 2 mm anterior and posterior, which is not indicative of significant instability. The criteria for significant instability are intersegmental movement of more than 4.5 mm. Fusion is also indicated for cases of primary mechanical back pain, revision surgery, infection, tumor or deformity, or after failure of two discectomies of the same discs. None of these conditions apply of this case. Additionally, a psychosocial screening for addressing confounding issues which may interfere with recovery should be documented prior to fusion surgery and was not provided in this case. Based on these factors, the request is not medically supported. The request for L4-L5 transforaminal interbody fusion, L4-L5 spinal monitoring, with three-days inpatient stay is not certified."*

On October 9, 2012, noted that the request for surgery had been denied. opined that the patient had primary mechanical back pain that was secondary to the left foraminal herniation, nerve root compression at L4-L5, L4 radiculopathy that correlated to the CT myelogram and L4 on L5 spondylolisthesis. The patient meets the ODG criteria. recommended continuing medications and requested an independent medical evaluation (IME).

Per the reconsideration review dated October 18, 2012, the appeal for L4-L5 trans-bilateral interbody fusion and L4-L5 spinal monitoring three-day inpatient stay was denied based on the following rationale: *"I spoke with who stated that the claimant had evidence of L4 and L5 radiculopathy on the left; however, physical exam findings do not correlate with the EMG. A physical exam on October 9, 2012, revealed normal quadriceps strength, normal anterior tibialis strength, normal big toe extensor strength and patellar reflexes were known to be 2+ bilaterally. A lumbar myelogram and CT dated May 7, 2010, revealed only a mild disc bulging at L4-L5 with no evidence of nerve root compression and no diagnosis of spondylolisthesis. An MRI dated February 20, 2012, revealed a minor equivocal finding at L4 on the left with no definite nerve root compression. A myelogram CT dated September 5, 2012, reports a left foraminal disc herniation and if there is a left L4 radiculopathy this may be significant. The EMG reports 1+ fibrillation in the left big toe extensor and no positive sharp waves and the vastus medialis reports 1+ fibrillation and 1+ positive sharp wave. These EMG findings are not corroborated by physical exam findings or normal strength and normal knee reflexes. There was no psychiatric evaluation included in the request. The Official Disability Guidelines (ODG) indications for fusion state until further research is conducted, there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains under study. The request does not meet guideline criteria and should not be certified".*

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

I reviewed the previous determination for L4-5 fusion. The MRI in this case shows no significant abnormalities which would justify fusion in a female.

Fusion is only considered reasonable if there is instability, a neural arch defect such as spondylolytic spondylolisthesis, or functional spinal unit failure.

With a normal appearing MRI, surgery cannot be certified in this case. I would therefore agree with the previous determination and uphold the previous adverse determination for L4-5 fusion in this case.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES