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Notice of Independent Review Decision

Date: September 24, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-5 ALIF instrumentation allograft iliac crest aspirate revision L4-5 laminectomy and posterior fusion with a 3 day inpatient stay. (22558, 22612, 22840, 22845, 22851, 63042, RC119, 38220, 20930)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board certified, neurological surgery

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:

Associates:
- Office visits (09/23/11 – 09/04/12)
- Diagnostics (09/29/11 – 04/24/12)
- Surgery (10/04/11, 05/14/12)
- Second opinion (08/30/12)

Management:
- Diagnostics (09/29/11 – 04/24/12)
- Office visits (10/04/11 – 07/30/12)
- Surgery (10/04/11, 05/14/12)

- Utilization reviews (08/10/12 – 08/30/12)

TDI:

- Utilization reviews (08/10/12 – 08/30/12)

ODG criteria has been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who slipped and fell on his lower back on a metal bar on xx/xx/xx. He developed back pain the next day.

2011: On September 23, 2011, D.O., evaluated the patient for pain in the midline of the lumbar region and flank area bilaterally. The pain was described as burning and stabbing and interfered with sleep. The patient was utilizing Flexeril, Lortab, Medrol Dosepak and Valium. Examination of the lumbar spine revealed severe tenderness in the midline at L5, tenderness off midline on the right in the paraspinous muscles, restricted active range of motion (ROM) secondary to pain, radicular pain into the right lower extremity, hypoesthesia in an L5 distribution on the right and positive straight leg raising (SLR) test on the right. X-rays of the lumbar spine were unremarkable. Dr. assessed lumbosacral neuritis and lumbar pain, recommended discontinuing Flexeril and Lortab and refilled Norco. Later, he prescribed Mobic and discontinued Medrol Dosepak.

Dr. obtained magnetic resonance imaging (MRI) of the lumbar spine that revealed complex left paracentral disc herination at L4-L5, broad-based component at the disc level contributing to moderate central canal and bilateral subarticular recess effacement affecting the intradural segments of the descending L5 nerve roots, inferiorly-directed extruded component on the left compressing the descending left L5 nerve root as it emerged at the thecal sac in the left lateral recess, facet arthrosis at L4-L5 and diffuse congenital narrowing of the lumbar canal.

On October 4, 2011, the patient was seen at Medical Center emergency room (ER) by, M.D., for left lower lumbar spine pain radiating to the left hip and thigh with urinary incontinence and loss of groin sensation. The patient also had some fecal incontinence, felt weak in both legs and had difficulty walking and standing. Examination of the back revealed soft tissue tenderness and limited ROM in the back. The patient was diagnosed with acute lumbar radiculopathy, to rule out cauda equina syndrome, incontinence and lower extremity weakness. Dr. treated him with IV Decadron and morphine.

An MRI of the lumbar spine was obtained and showed a small disc herniation at the L4-L5 level compressing the thecal sac and proximal L5 nerve roots with a small extruded fragment just below the level of the disc space in the midline.

On October 4, 2011, M.D., performed emergency surgery consisting of laminectomy at L4-L5 bilaterally as well as right side L4-L5 micro discectomy. The patient was discharged on October 6, 2011.

Postoperatively, Dr. noted ongoing back pain that was referred to the right thigh. He recommended initiating physical therapy (PT).

On follow-up, Dr. prescribed Mobic and Norco.

From November through December, the patient attended three sessions of PT. However, PT was kept on hold when the patient had exacerbation of his right leg, buttock and low back pain with flexion movements. According to the therapist, he had developed nerve root impingement and was concerned due to reported difficulty with bladder.

2012: Dr. noted that the patient was doing well, status post lumbar laminectomy and microdiscectomy with good improvement of the radicular symptoms. He recommended continuing pain management and PT.

From January through April, Dr. maintained the patient on medications consisting of Neurontin, Norco, Medrol, Mobic and Naprosyn. He recommended weight reduction and opined that the patient was unable to work.

In April, MRI of the lumbar spine with and without contrast revealed post discectomy changes at L4-L5. The current study suggested that recurrent central and right paracentral disc herniation with probable impingement of the crossing right L5 nerve root and mild degenerative disc space and degenerative facet change at L5-S1 without focal disc herniation or nerve root impingement at that level.

On May 14, 2012, Dr. performed right L5 transforaminal epidural steroid injection (ESI). The patient reported slight improvement initially; however, the pain returned after two days. Dr. recommended repeat ESI, which was denied. Dr. noted an antalgic gait, restricted ROM due to the gluteal pain on the right and posterolateral hip pain on the right only, hypoesthesia in the thigh over the lateral aspect of the distal half on the right side and positive SLR on the right producing leg pain and buttock pain. Contralateral SLR on the left was positive for leg pain. Dr. recommended surgical evaluation by Dr..

In June, Dr. opined that the patient had failed all available conservative treatment and his pain and neurologic symptoms were still too severe to continue long-term conservative treatment. He discussed operative indications for anterior lumbar interbody fusion (ALIF) at L4-L5 with instrumentation and removal of the recurrent herniated disc fragment through a previously un-operated area, possible lumbar decompressive laminectomy and fusion with instrumentation. He recommended complete smoking cessation prior to scheduling the surgery.

In June and July, Dr. maintained the patient on Norco.

Per utilization review dated August 10, 2012, the request for arthrodesis, anterior interbody tech (22558), posterior lumbar fusion (22612), post instrumentation without segmental fixation (22840), anterior instrumentation (22845), application of prosthetic device (22851), lumbar laminectomy/discectomy (63042), inpatient other (RC119), bone marrow aspiration (38220) and allograft spine surgery morselized (20930) was denied with the following rationale: *"Based on the medical records submitted for review on the above-referenced claimant, lumbar fusion is not authorized. Claimant does not meet ODG criteria. There is no evidence of instability. Recurrent disc herination alone is not an indication for lumbar fusion. Per office visit with Dr. June 21, 2012, he will need to stop smoking entirely prior to scheduling surgery, has failed conservative treatment, recommends ALIF L4-L5 with instrumentation and anterior or posterior stabilization and removal of the recurrent herniated disc fragment and possible decompressive laminectomy and fusion with instrumentation, the patient is status post emergent L4-L5 laminectomy and right L4-L5 microdiscectomy by Dr. on October 4, 2011, for lumbar herniated disc and stenosis with cauda equina syndrome, he developed worsening pain to the right L5 distribution in April of 2012 after PT to treat his back pain, severity is average 8/10, it radiates in a radicular fashion, he has been treated with medications/hot packs/PT/spinal injections without relief, current tobacco usage none; exam reveals mild tenderness off midline only on the right in the paraspinous muscles, lumbar flexion and extension mildly restricted on the right, neuromuscular exam normal, bilateral lower extremity exam normal, sensory exam reveals right lower extremity "hypesthesia in an L4 distribution 50% of normal/L5 distribution 50% of normal/S1 distribution 50% of normal, DTRs 1+ throughout the lower extremities, ankle clonus is absent, SLR is positive on the right, contralateral SLR on the left is positive producing contralateral leg pain, radiological exam flexion/extension/AP/ lateral with bending views lumbosacral reveals soft tissue normal, bone quality normal, no pathological bone lesions, normal disc space height, alignment satisfactory, no endplate changes, no fractures seen, no evidence of previous surgery, impression normal x-rays study of the lumbosacral spine. MRI of April 24, 2012, reveals post discectomy changes at L4-L5, recurrent central and right paracentral disc herniation with probable impingement of the crossing right L5 nerve root and mild degenerative disc space and facet change at L5-S1 without focal disc herniation or nerve root entrapment at this level".*

On August 30, 2012, M.D., performed a second opinion evaluation of MRI of the lumbar spine without IV contrast dated September 29, 2011, and MRI of the lumbar spine with and without IV contrast dated April 24, 2012. She opined that the initial MRI of September 29, 2011, showed moderate diffuse posterior spondylosis at L4-L5 with superimposed 5-mm left paracentral, inferiorly-directed disc extrusion with probable sequestered disc fragment causing mass effect on the left L5 root sleeve, moderate central and mild bilateral lateral recess stenosis. The disc extrusion might represent a posttraumatic process related to the date of injury of September 13, 2011, or more chronic disc extrusion. One would need to correlate with new left radiculopathy. The second MRI of the April 24, 2012, showed the patient to be status post right posterior laminectomy since the initial

study. It was uncertain why a right-sided laminectomy was performed in that the disc extrusion was on the left other than the possibility that the patient had symptoms on the right. There was a moderate post discectomy bulge more on the right. There was moderate right anterior epidural enhancement surrounding the right L5 nerve root sleeve in the right lateral recess compatible with granulation tissue. One sagittal image demonstrated a small 2-mm focus of non-enhancement right paracentrally that could represent a small retained disc fragment, postoperative change with non-enhancing material or a recurrent disc protrusion. Mild effacement of the right L5 nerve root sleeve was evident. The evaluator was unable to comment on treatment options in that that was a clinical assessment and there was no evidence of instability.

Per utilization review dated August 30, 2012, the reconsideration request for arthrodesis, anterior interbody tech (22558), posterior lumbar fusion (22612), post instrumentation without segmental fixation (22840), anterior instrumentation (22845), lumbar laminectomy/discectomy (63042), bone marrow aspiration (38220) and allograft spine surgery morselized (20930) was denied with the following rationale: "*This patient had an L4-L5 decompression with disc excision associated with a cauda equina syndrome. There is a now a recurrent disc herination at L4-L5. The ODG would suggest that a repeat disc excision would be preferred for the recurrent disc versus a fusion surgery. The patient was a smoker but was attempting to quit. There was no psychological assessement noted. Further validation is needed for this proposed fusion surgery.*"

On September 4, 2012, Dr. noted that the entire low back pain referred to the right hip, the posterior aspect of calf of the right lower leg and posterior aspect of the right ankle. The patient was utilizing Lyrica, Naprosyn and Norco. Dr. discontinued Naprosyn and changed Norco to 10/325 mg one tab q.i.d.

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

This is the case of a young man born on xx/xx/xx, who injured his back in a slip and fall on a metal bar on xx/xx/xx.

He had back pain and was seen by Dr., an osteopathic orthopedist, in An MRI was done which showed a left-sided herniated disc with extrusion inferiorly and some lateral recess and central stenosis.

The patient had neurological abnormalities in the right lower extremity consistent with an L5 nerve root as well as incontinence and some bowel problems.

Medrol Dosepak, Valium and Norco were given and the patient was seen by Dr. , a partner of Dr..

He was admitted to Medical Center and on October 4, 2011, had a microdiscectomy at L4-L5 on the right performed by Dr..

Postoperatively, the patient improved but had a stormy course without ever really completely resolving his difficulty. He continued to have straight leg raising and at times it decreased. He continued to have back pain and neurologically he improved.

Therapy was tried, medications were tried, and he was placed on Lyrica and Neurontin in early 2012 with some mild improvements.

He continued to be managed conservatively. Interestingly, all during this time, his blood pressure was noted to be extremely elevated and I saw no mention of any medications or referral for treatment of his blood pressure.

He continued to be followed by Dr. and Dr. Repeat imaging study was performed on April 24, 2012, with and without contrast which showed some recurrent central herniated disc with L5 impingement and some postoperative scarring. There was a mild bulge at L5-S1.

On May 14, 2012, at Surgical Center, Dr. performed an L4-L5 right epidural steroid injection. Apparently there was not a significant amount of improvement and the patient was sent to Dr. again.

Dr. evaluated the situation and felt that the patient needed an ALIF as well as probably a posterior revision and fusion with hardware. Again, the blood pressure was noted to be extremely high. The patient was a smoker and continued to smoke. He also was 5’9” and 158 pounds all during this time.

The patient’s chart was reviewed after the request was made by Dr. for the surgical procedure by Dr. who did not feel that the procedure requested did not meet the criteria of the ODG. Dr. reviewed the MRIs and pointed out that the original abnormalities were on the left side and the surgery was performed on the right side. She also clearly described the abnormalities noted on the imaging study.

When last seen, the surgery was still requested and the blood pressure was noted to be continually high at 180/100.

Based on the information provided, and the ODG criteria, the patient does not meet the criteria for an ALIF and posterior surgery of decompression and possible fusion with instrumentation.

Clearly, there is no evidence of demonstrable instability or chronic arthritic change. The patient has had a recurrent and/or contained disc in that the original radiographic imaging study revealed the disc on the left and the surgery was on the right. There is no severe narrowing of the disc space described and for that reason this patient does not reach the criteria for which the ODG recommends that which has been requested to be performed.

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

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