

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

Notice of Independent Review Decision

August 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar laminectomy with fusion L3-L4 (63047, 63048 x3, 22612, 22614 x3 and 20937) and length of stay (LOS) for one to two days

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 (06/10/13, 07/15/13)
- Office visits (05/13/10 – 05/30/13)
- Diagnostics (08/17/10, 05/21/13)
- Diagnostics (10/12/11, 10/26/12, 02/22/13, 05/21/13)
- Office visits (11/30/11, 03/23/12, 04/25/13, 05/30/13)
- Utilization reviews (06/10/13, 07/15/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his lower back on xx/xx/xx. He was walking next to a pickup truck when he slipped on ice and started to fall. He caught himself before hitting the ground but did the splits and twisted. He had onset of low back pain and right leg pain.

On May 13, 2010, the patient was evaluated for low back pain and posterior thigh pain between 45 and 60 degrees. The patient walked with a slightly flexed posture at the low back and had some loss of lumbar lordosis with paralumbar muscular tightness. There were no significant sensory deficits in the lower extremities. The patient had developed a chronic posttraumatic mechanical low back disorder with discopathy and probable radiculopathy. He discussed treatment options with the patient and recommended obtaining a lumbar magnetic resonance imaging (MRI) scan for further investigation.

On August 17, 2010, the patient was seen for low back pain and leg pain. A lumbar myelogram was performed, which showed postoperative change at L5-S1 secondary to posterior decompression, posterior fusion and anterior interbody fusion. Bilateral posterior pedicle screws were present at L5. An orthopedic suture was noted transfixing the posterior spinous processes of L5 and S1. Bilateral inter-disc spacers were present within the L5-S1 disc space. There was mild anterior extradural defect at L2-L3, L3-L4 and L4-L5 levels. Computerized tomography (CT) scan of the lumbar spine post myelogram showed the following: At L2-L3 disc space, minimal broad-based bulging of the disc causing minimal encroachment upon the anterior aspect dural sac. Mild degenerative changes present involving the facet joints and thickening of the ligamentum flavum posteriorly. Findings caused mild spinal canal stenosis. At L3-L4 disc space, mild broad-based bulging of the disc noted causing mild encroachment upon the anterior aspect of the dural sac and neural foramina. Degenerative changes were present involving the facet joints with facet laxity. There was thickening of the ligamentum flavum posteriorly. The findings caused mild spinal canal stenosis and mild right-sided neural foraminal stenosis. At L4-L5 disc space, there was mild narrowing of the disc space. Mild broad-based bulging of the disc was noted causing mild encroachment upon the anterior aspect of the dural sac and neural foramina. There were mild degenerative changes involving the facet joints with facet laxity. Thickening of the ligamentum flavum was noted posteriorly. The findings caused mild spinal canal stenosis. At L5-S1 disc space, there was postoperative change secondary to posterior decompression with bilateral posterior fusion and anterior interbody fusion. Bilateral inter-disc spacers were present within the L5-S1 disc space, bilateral facet screws were present and seated, orthopedic fixation wire was noted transfixing the posterior spinous processes of L5 and S1. Bilateral lateral bony fusion processes extended from L5 through S1.

On October 11, 2010, wrote a letter stating that the patient had a recent lumbar myelogram and CT scan. The study had showed central defects at L2-L3, L3-L4 and L4-L5, but no tight stenosis, definite root compression, or extruded disc. The patient had bilateral hip and leg pain mainly on the right, further stated that treatment options were discussed with the patient and his wife including a right

L4-L5 epidural steroid injection (ESI) with Depo-Medrol. A prescription had been given for Hydrocodone 7.5 mg. The patient was to see for chronic pain management and if he did not improve with this, he could be a candidate for a trial spinal cord stimulator (SCS).

On October 12, 2011, performed electromyography/nerve conduction velocity (EMG/NCV) study of the lumbar paraspinal muscles. This was essentially a normal study without convincing evidence for a compressive or other mononeuropathy, polyneuropathy or bilateral lumbosacral radiculopathies.

On October 18, 2011, evaluated the patient for pain primarily in the lumbar spine and radiating to the right hip. This was an essentially constant pain. The patient reported that he slept in a recliner either on his back or side approximately three to four hours per night. He had been treated earlier with chiropractic care and physical therapy (PT) with no relief and had injections in May 2010, which helped in relieving the pain going down the right leg. Per history was significant for bulging lumbar disc and lumbar facet arthropathy from L3 through L5 and a 360-degree fusion at L5-S1 in 1989. Examination of the back showed flexion 30 degrees, extension 5 degrees both causing back and right hip pain; tenderness to the right L4-L5 facets, bilateral L5-S1 and bilateral sacroiliac (SI) joints. Kemp's and Yeoman's tests were positive and there was a well-healed scar from L4 through S1. An MRI of the lumbar spine from May 27, 2010, was interpreted as showing status post L5 laminectomy and L5-S1 discectomy and fusion, annular bulges from L1-L2 through L4-L5 with mild-to-moderate spinal stenosis at L2-L3 through L4-L5. At L3-L4, the disc touched, but did not displace the exiting left L3 nerve root. Also noted was degenerative disc disease (DDD) at T12-L1. The assessment was L3-S1 facet arthropathy, bulging lumbar disc, lumbalgia, hypertension and tobacco abuse. prescribed Lortab and Flector patches and recommended obtaining a urine drug screen (UDS) if Lortab was refilled. He opined that the patient would benefit from a right L4 through S1 and left L5-S1 facet/hardware injection. The patient was referred back for a transcutaneous electrical nerve stimulation (TENS) unit.

On March 23, 2012, the patient was evaluated by a pain management specialist, on referral. The handwritten records indicate that on xx/xx/xx, the patient was walking next to a truck when he slipped on ice and started to fall. He caught himself before hitting the ground, but did a motion similar to splits. He twisted and had the onset of low back pain and right leg pain. It was noted that since then, the patient had a lumbar ESI and the leg pain was controlled. The pain score was 6/10, constant, aching and with buttock pain right more than left. His low back pain was more than the hip pain. He did report pins and needles sensation in the right low back into the right buttock. The following diagnostic studies are mentioned in this handwritten report, which is difficult to decipher: On May 27, 2010, MRI was performed showing status post L5 laminectomy and L5-S1 discectomy/fusion, annular bulges at L1-L2 through L4-L5 and mild-to-moderate stenosis from L2-L3 through L4-L5. A CT scan performed on March 31, 2010, indicated L4-L5 facet hypertrophy of moderate prominence, L3-L4 mild facet hypertrophy and 360-degree fusion at L5-S1 with prior laminectomy at L5. The

patient apparently had four weeks of PT which actually made his symptoms worse. He had also undergone a lumbar ESI. in July 2010. On examination of the back, flexion was 60 degrees with pain on arising and extension was 5 degrees and painful. The spinous processes were tender at L4-L5 and there was paraspinous tenderness to palpation bilaterally from L3-L4 through L5-S1. Straight leg raising (SLR) was positive on the right at 75 degrees causing low back pain. Deep tendon reflexes (DTRs) were 2+ and equal in the lower extremities. The assessment was chronic lumbar pain syndrome, lumbar spondylosis and post lumbar laminectomy syndrome at L5. The plan was bilateral lumbar medial branch nerve block from L3 through L5, initiating Hydrocodone 7.5/500 mg and obtaining flexion/extension films of the lumbar spine.

On October 26, 2012, a CT scan of the lumbar spine showed spondylosis of the lumbosacral spine, prior L5-S1 laminectomy with fusion without loosening of bone plugs or surgical hardware.

On February 22, 2013, MRI of the lumbar spine showed at L1-L2, a broad disc bulge with facet disease and stenosis of the lateral recesses; at L2-L3, broad disc bulge flattening the thecal sac with minimal facet disease; at L3-L4, broad disc bulge with facet disease, stenosis of the lateral recesses bilaterally and spinal stenosis; and at L4-L5, mild disc bulge with flattening the thecal sac. The L5-S1 level demonstrated fusion of the posterior elements with cerclage wires and bilateral facet screws. The impression was multilevel DDD with mild disc bulges predominantly causing stenosis of the lateral recesses.

On April 25, 2013, evaluated the patient. The patient reported ongoing severe chronic mechanical low back pain and bilateral radiating hip and leg pain, worse on the right. The pain had gotten much worse since October 2012. On examination, the patient had total loss of lumbar lordosis. The patient walked with a flexed posture at the low back and had a right antalgic gait. He had paralumbar muscle tightness, positive SLR on the right at 30 degrees and on the left at 45 degrees, DTRs were trace in the knees and absent in the ankles. Sensation was diminished below the knees bilaterally associated with weakness from the quadriceps distally. opined that the patient had severe posttraumatic multilevel lumbar disc pathology with chronic mechanical low back disorder and stenosis, with radiculopathies and neurological deficit. ordered a lumbar myelogram to further assess the condition.

On May 21, 2013, a lumbar myelogram was performed. The indications for the procedure were severe right leg radicular pain secondary to lumbar disc disease and failure to improve with conservative measures. The myelogram demonstrated mild anterior extradural defects at L1-L2, L2-L3 and L3-L4; apparent mild-to-moderate spinal canal stenosis at L2-L3, L3-L4 and L4-L5; postoperative changes at L5-S1 with bilateral posterior bony fusion and bilateral facet screws at L5-S1. Post myelogram CT scan revealed mild-to-moderate spinal canal stenosis from L2-L3 through L4-L5, mild facet joint laxity and degenerative change noted at these levels and postoperative changes at L5-S1.

On May 30, 2013, stated that the recent myelogram confirmed the MRI scan findings done in February. He believed that the major problem was at L3-L4 level. The patient and his wife wanted to proceed with surgery due to the constant ongoing pain preventing him from work. decided to do a right-sided decompression mainly at L3-L4 with excision of the extruded disc and nerve root decompression with posterolateral fusion, probably just on the right, but without instrumentation.

Per utilization review dated June 10, 2013, the request for lumbar laminectomy with fusion at L3-L4 with length of stay for one to two days was denied based on the following rationale: *“The clinical documentation submitted for review fails to meet the evidence-based guidelines for the requested service. The clinical documentation submitted for review evidences the patient continues to present with lumbar spine pain complaints status post a work related fall with injury in xx/xxxx. The clinical notes document the patient utilized lower levels of conservative care, most recently right after his injury for his lumbar spine pain complaints. The requesting provider, is recommending the patient undergo an L3-L4 laminectomy with posterolateral fusion. However, the patient is already status post a lumbar fusion at the L5-S1 performed in 1989. The clinical notes lack evidence of the patient having undergone a psychological evaluation to support the requested intervention, as recommended per guidelines to address any confounding issues that may impede on postoperative recovery. In addition, the imaging study of the patient’s lumbar spine evidenced facet arthropathy; however, there was no documentation of any nerve root involvement to support decompression at the L3-L4 level. Given all the above, the request for Length of Stay 1-2 Days for Lumbar Laminectomy w/Fusion L3-L4 63047, 63048 x3, 22612, 22614x3, 20937 is non-certified.”*

Per reconsideration review dated July 15, 2013, the appeal for lumbar laminectomy with fusion at L3-L4 with two days length of stay was denied with a following rationale: *“The. request for a lumbar laminectomy with a fusion and 1 to 2. day inpatient stay is non-certified. The documentation submitted for review elaborates the patient complaining of a long history of ongoing low back pain despite a previous surgery and numerous conservative modalities. The Official Disability Guidelines recommended laminectomy and fusion in the lumbar region provided the patient meets specific criteria to include a definitive surgical plan in place. The clinical notes do mention an L3-L4 involvement; however, it does not appear that a probable right-sided procedure is planned. However, without a more definitive surgical plan in place, this request is not indicated. As such, the documentation submitted for this review does not support the request at this time. Based on the clinical information submitted for this review and. using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.”*

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

The request for laminectomy with fusion L3-L4 (63047, 63048 x 3, 22612. 22614 x 3 and 20937) would not be considered reasonable or medically necessary based on the following rationale. The evidence based Official Disability Guidelines state that lumbar fusion is indicated for individuals with signs of structural instability or more compelling indication such as progressive neurologic deficit or tumor. In general they do not recommend it for degenerative conditions of the lumbar spine. The clinical impression is the claimant has pathology at the L3-4 level to explain the back and lower extremity complaints. With careful review of the records there is a less than clear picture that L3-4 is in fact the offending level. The imaging studies to date document varying degrees of pathology in the lumbar spine at multiple levels but there does not appear compelling evidence at L3-4 is the offending level in this case. There is no discussion of recent EMGs or specific findings on examination that would state that this particular level is the source of the claimant's pain complaints. Furthermore the claimant appears to be under care following previous lumbar fusion surgery and continues to have ongoing pain complaints which raise questions as to the likelihood that additional surgery is going to result in meaningful improvement. Lastly the evidence based Official Disability Guidelines specifically point out that all confounding psychosocial variables must be addressed in advance of any type of fusion surgery. It does not appear within the record that his has been addressed either. In summary the claimant does not have a clear picture of structural instability lumbar spine nor do they have convincing evidence of radiculopathy that is isolated to the L3-4 level that would warrant decompression and/or fusion in that setting. In addition there is no discussion whether or not a psychological evaluation has been completed. Based on all this information provided and what appears to be a less than clear cut clinical picture identifying the specific level this claimant pain complaints. The request for intervention would not be considered medically necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES