

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

Notice of Independent Review Decision

May 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-S1 hardware removal, lateral recess decompression at left L4-L5, wide decompression at bilateral L2-L3 with discectomy, stabilization and fusion, with two-three days of inpatient hospital 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:

Broadspire:

- Diagnostics (11/18/10 – 01/16/13)
- Surgery (02/28/11)
- Office visits (03/10/11 – 01/24/13)

- Therapy (03/17/11 – 06/14/11)
- Reviews (10/30/12)
- Utilization reviews (02/04/13, 04/01/13)

Spine Associates:

- Office visits (09/23/10 – 01/24/13)
- Diagnostics (11/18/10 – 01/16/13)
- Surgery (02/28/11)
- Reviews (10/30/12)

TDI:

- Utilization reviews (02/04/13, 04/01/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported that on xx/xx/xx, she was a victim of a prank. She was an LVN and was working in the surgical department of a hospital. Multiple other employees grabbed her and began to wrestle her and pretend that they were going to tie her to the surgical table. She was not aware of the prank. She resisted and sustained an injury to the low back.

2001 – 2009: No records are available.

2010 – 2011: On September 23, 2010, M.D., an orthopedic surgeon, evaluated the patient for history of chronic low back pain and left lower extremity pain that started in September 2001 when the patient was involved in a work-related injury. At that time, she was walking into an operating room (OR) where she was a nurse when several of her coworkers decided to play a trick on her. They grabbed her and strapped her down on the table and as she was fighting and wriggling and twisting in order to get released, she developed pain in her low back. Subsequently, she had ongoing low back pain and left lower extremity symptoms that persisted. The pain would travel down the left lower extremity going all the way to the calf and foot with numbness and tingling into the calf and foot as well. There was weakness and tiredness on the left, difficulty ambulating and limitation of walking distance to two blocks. Back pain was mechanical in nature with exacerbation noted with ambulating, bending, lifting, twisting, turning and carrying. Dr. reviewed the medical records dating back to 2001. The studies indicated that the patient was seen by Dr. who had recommended a laminectomy, decompression and fusion procedure over the L3-L4 and L5-S1 levels but the patient had declined the procedures. In 2008, the patient was seen by Dr. for a required medical evaluation (RME). He had recommended surgical treatment in the form of laminectomy and fusion procedure. Examination showed inability to walk on the toes indicating weakness of the gastroc-soleus muscles on both sides. The patient was able to walk on the heels though she had pain when doing so and had to stop after only a few steps. She was able to flex to approximately 40 degrees but could not extend all the way to the neutral position. She was standing in a forward flexed position. There was no evidence of nerve root

tension signs. Neurological testing showed evidence of S1 motor weakness on both sides. Dermatomal sensory function was diminished over the L5 and S1 dermatomal areas on the left side. X-rays of the lumbar spine showed evidence of disc space narrowing at L4-L5 and L5-S1 and anterolisthesis of L4 on L5. There was evidence of a spondylosis of L4 on the oblique views. Flexion and extension studies were done; however, the effort was extremely poor on account of the patient's pain. Dr. diagnosed neurogenic claudication, likely spinal stenosis and history of disc herniation to the lower lumbar spine with radiculopathy dating back over nine years. He prescribed a combination of Darvocet, Flexeril and ibuprofen. He ordered an updated magnetic resonance imaging (MRI) study and electromyographic studies.

On November 18, 2010, M.D., performed electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities that showed chronic bilateral S1 root irritation consistent with radiculopathy and bilateral underlying sensory and motor polyneuropathy.

On November 18, 2010, MRI of the lumbar spine showed severe bilateral facet arthropathy and grade I anterolisthesis at L3-L4 and L4-L5, severe central canal stenosis at L4-L5 and to a lesser extent at L3-L4, severe multilevel degenerative thoracolumbar disc disease and moderate bilateral foraminal stenosis at L2-L3, L3-L4, L4-L5, and L5-S1.

On November 20, 2010, Dr. reviewed MRI and noted that the patient had primarily leg symptoms and this had occurred on account of the stenosis that she had. He opined that the patient would require wide bilateral decompression at both L3-L4 and L4-L5.

On February 28, 2011, Dr. performed harvesting of autograft bone through a separate skin and fascial incision, partial laminectomy at L3 and L5 bilaterally, bilateral hemi-laminectomy at L4, wide bilateral decompression at L3-L4 and L4-L5, decompression of the thecal sac and nerve roots at L3-L4 and L4-L5, posterior spinal fusion at L3-L4, L4-L5 and L5-S1, posterior spinal instrumentation at L3, L4, L5 and S1 segments, insertion of epidural catheter with instillation of Duramorph for postoperative pain control and application of Solu-Medrol to the nerve roots.

On February 28, 2011, x-rays of the lumbar spine showed posterior fusion with metallic instrumentation at L3-S1 levels and bilateral L3-L5 transpedicular and bilateral S1 trans-alar screws in place, transfixed with metallic rods and L4 and L5 laminectomy defects.

On March 3, 2011, flat and upright KUB was performed for constipation. The study showed postsurgical changes in the lumbar spine with subtle linear radiopacity to the right of lower lumbar spine extending into the pelvis which likely represented a small tube or drain.

On March 10, 2011, Dr. noted that the patient was doing very well and was extremely pleased with the results of the surgery. X-rays of the lumbar spine showed normal lumbar lordosis, good placement of the hardware over the L3, L4, L5 and S1 segments, no bony or soft tissue abnormalities and normal paravertebral soft tissue spaces. Dr. recommended starting physical therapy (PT) focusing on core truncal strengthening program.

From March 17, 2011, through June 14, 2011, the patient attended therapy consisting of therapeutic exercises and neuromuscular re-education.

On July 21, 2011, Dr. noted that the patient complained of discomfort over the left posterior iliac crest area on the left side where the bone graft was taken. Examination showed some difficulty with heel walking, negative SLR and no evidence of nerve root tension signs. X-rays of the lumbar spine showed good placement of the hardware L3 to S1 segments. Dr. recommended follow-up in one year.

2012: On September 6, 2012, Dr. evaluated the patient for development of pain in the left buttock, which radiated down the left lower extremity. The majority of the pain was in the buttock and it radiated distally with paresthesias involving the entire left foot. The patient had perception of weakness in the left lower extremity. The patient was utilizing Advil for pain. History was positive for hypertension. Examination showed healed midline scar over the lower lumbar spine and a healed scar over the posterior iliac crest on the left. There was tenderness directly over the posterior superior iliac spine and the left side and positive Faber test and modified Faber test on the left. Straight leg raising (SLR) reproduced buttock pain. Dermatomal sensory testing was diminished over the calf and the distribution of the L5 dermatomal area. Deep tendon reflexes (DTRs) were depressed bilaterally symmetrically. Examination showed pedicle screws and rods in place from L4 to S1, evidence of decompression performed over the lower lumbar spine and bridging bone posterolaterally from L3 to S1. Dr diagnosed sacroiliac (SI) joint mediated pain on the left side and possible true lumbar radiculopathy on the left side. He recommended further evaluation with a computerized tomography (CT) scan of the lumbar spine and lower extremity electromyographic (EMG) studies. He also recommended a diagnostic left SI joint block.

On October 30, 2012, M.D., performed a designated doctor exam (DDE) and noted that MRI of the lumbar spine dated November 5, 2001, showed small anterior vertebral osteophytes, small central disc protrusion at L3-L4, right posterolateral disc herniation at L5-S1 level producing nerve root compression, disc degeneration and desiccation with marked interspace narrowing at this level and facet arthropathy. The patient had also undergone medical records review by M.D., who opined that all the conditions currently found in the lumbar spine at the time of the review were related to pre-existing conditions and the natural course of the conditions as ordinary disease of life. He stated they were not related to the work-related injury. Dr. opined that the extent of injury was lumbar sprain,

lumbosacral spondylosis without myelopathy, spinal stenosis, lumbar neurogenic claudication (L3-S1 bilaterally), displacement of lumbar intervertebral disc without myelopathy (L3-L4, L4-L5 and L5-S1), degeneration of thoracic or thoracolumbar intervertebral disc (L3-L4, L4-L5 and L5-S1), acquired spondylolisthesis and thoracolumbosacral neuritis or radiculitis, unspecified. The disputed areas included multilevel degenerative disc disease (DDD) of the lumbar spine, spondylolisthesis at L4-L5, chronic lumbosacral sprain and superimposed lumbosacral radiculitis.

On December 20, 2012, Dr. again requested for a CT myelogram study.

2013: On January 16, 2013, the patient underwent CT-myelogram of the lumbar spine, which revealed the following findings: (1) At T10-T11, a 3 to 4 mm bulge moderately indenting the sac, mild facet arthrosis and marked left foraminal narrowing. (2) At T11-T12, marked disc space narrowing with 4-mm spondylotic bulge. There was moderate to marked facet arthrosis particularly on the left with indentation of the left posterior cord. Moderate central canal stenosis was present. There was bilateral lateral recess stenosis and marked bilateral foraminal narrowing with effacement of the T11 nerve root sleeves. The cord was effaced. The left T12 nerve root sleeve was under filled. (3) At T12-L1, disc space narrowing and 2-mm retrolisthesis of T12, a 5-mm bulge was present. There was moderate to marked facet arthrosis with ligamentum flavum hypertrophy. Central canal stenosis was present. There was right lateral recess stenosis and large right and mild-to-moderate left foraminal narrowing present with effacement of the right T12 nerve root sleeve. The L1 nerve root sleeves were under filled. (4) At L1-L2, a 5-mm bulge with mild-to-moderate facet arthrosis and ligamentum flavum hypertrophy. Central canal stenosis was present. There was mild bilateral lateral recess stenosis. Moderate bilateral foraminal narrowing was present with effacement of the L1 nerve root sleeves. (5) At L2-L3, there was marked disc space narrowing and 4-mm anterolisthesis of L2. Marked facet arthrosis was present. There was 9-mm posterior protrusion with marked central canal stenosis. There was marked effacement of the contrast column. There was bilateral lateral recess stenosis and marked bilateral foraminal narrowing with effacement and displacement of the L2 nerve root sleeves. The right L3 nerve root sleeve was under filled while the left filled normally. (6) At L3-L4, evidence of posterior fusion and a 3-mm bulge mildly indenting the sac. Laminectomy defects were present. Posterior fusion was continuous. Transpedicular screws were present with posterior instrumentation without evidence of loosening or migration. There was no central canal or lateral recess stenosis. Mild to moderate right and mild left foraminal narrowing was present without nerve root effacement. (7) At L4-L5, there was moderate disc space narrowing and 4 mm anterolisthesis of L4. There were laminectomy defects and posterior fusion. There was left lateral recess stenosis and moderate right and marked left foraminal narrowing with effacement of the left L4 nerve root sleeve. (8) At L5-S1, marked disc space narrowing was present. There was a 3-mm spondylotic bulge minimally effacing the sac and S1 nerve root sleeve. Posterior fusion was continuous bilaterally. There was mild left lateral recess

stenosis with moderate-to-marked right and marked left foraminal narrowing with effacement of the L5 nerve root sleeves, left greater than right. The S1 nerve root sleeves were minimally effaced and filled normally. There was a large bone graft donor site in the posterior left ilium. There was osteoarthritis of both SI joints, left greater than right.

On January 24, 2013, Dr. noted that the CT myelogram showed evidence of a large disc herniation associated with spondylolisthesis of L2 on L3 and severe spinal stenosis from thecal sac compression at L2-L3. Additionally, a left-sided lateral recess stenosis was noted at the L4-L5 level and a healed fusion was demonstrated. The patient reported increased worsening of her symptoms with inability to ambulate. She used a cane as her walking distance was severely reduced and this was because of neurogenic claudication. Dr. recommended surgical treatment because of severe stenosis at L2-L3 level. Specifically hardware removal was recommended with a wide bilateral decompression and discectomy at L2-L3 followed by a fusion at that level. A fusion was indicated because of the instability that would be created from the wide decompression at the L2-L3 level. The hardware over the L3 to S1 levels would be removed and would not need to be replaced as the fusion was healed.

Per utilization review dated February 4, 2013, D. M.D., denied the request for L3-S1 hardware removal, lateral recess decompression at left L4-L5, wide decompression at bilateral L2-L3 with discectomy, stabilization and fusion, with two-three days of inpatient hospital stay. Rationale: *“Based on the Official Disability Guidelines the role of the proposed surgery cannot be supported. The claimant is noted to be with continued complaints of pain, there is no formal physical examination findings demonstrating specific neurologic compromise to the lower extremities to support the role of the above mentioned procedure. While the claimant's myelogram also demonstrates evidence of effacement of the exiting nerve roots at L2-L3 and L4-L5 level it should be noted there is no clinical understanding of instability that would warrant or justify the role of fusion procedure. Given the above, the specific request would fail to meet the Official Disability Guidelines criteria for necessity. It must also be taken into account that there is limited understanding of conservative care documented for review.”*

Per reconsideration review dated April 1, 2013, M.D., denied the appeal for lumbar hardware removal at L3-S1, lateral recess decompression L4-L5 left side, wide bilateral decompression L2-L3 with discectomy, stabilization and fusion L2-L3 as inpatient with 2-3 days inpatient stay based on the following rationale: *“The guidelines state that before discectomy and lumbar fusion, all pain generators have to be identified and treated. There is no documentation of lower levels of conservative care of muscle relaxants or a home-based exercise program. There is no documentation of lower levels of conservative care of lumbar epidural steroid injections. There is no documentation of lumbar spine instability documented on flexion and extension views, which is required by the guidelines. The guidelines would support a psychological screening to be performed to address confounding issues, especially in a claimant who has undergone previous lumbar fusion. With*

no documentation of lumbar instability and with no documentation of exhaustion of all lower levels of conservative care and without a psychosocial screening, the request would not be medically supported. The request for lumbar hardware removal at L3 to S1, lateral recess decompression L4-L5 left side, wide bilateral decompression L2-L3 with discectomy, stabilization and fusion L2-L3, as inpatient with two to three days inpatient stay is not certified.”

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

On careful overview, it appears that successful fusion was undertaken in this case. There now appears to be a disc herniation above. The rationale for decompressing this area to alleviate neurogenic claudication is clear. The rationale for the extensive nature of this procedure to include not only hardware removal but the addition of an additional level of fusion is not clear. For these reasons upon review, this reviewer would recommend that the previous adverse determination be upheld.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES