

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

Notice of Independent Review Decision

November 18, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-S1 laminectomy, single segment/fusion

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:

- Utilization reviews (10/17/13, 10/25/13)
- Office visits (06/17/13 – 10/23/13)
- Diagnostics (06/19/13 - 09/27/13)
- Procedure (07/25/13)
- Utilization reviews (10/17/13, 10/25/13)
- Office visits (06/17/13 – 09/23/13)
- Diagnostic (06/19/13 - 09/27/13)
- Procedure (07/25/13)
- Utilization reviews (10/17/13, 10/25/13)
- Review (10/31/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury on xx/xx/xx. He experienced immediate low back and left buttock pain.

On June 17, 2013, the patient was evaluated for low back pain. The pain was located in the left lumbar area radiating to the left leg. The patient described his pain as intermittent. He had tried non-steroidal anti-inflammatory drugs (NSAIDs) and therapy with no symptom relief. On examination, there was full range of motion (ROM) with pain. There was no tenderness, no spasm or curvature noted. The reflexes, gait and strength was normal and straight leg raise (SLR) was negative. diagnosed lumbar strain and ordered magnetic resonance imaging (MRI) of the lumbar spine.

On June 20, 2013, MRI of the lumbar spine revealed multilevel degenerative disc disease (DDD) and facet arthropathy of the lumbar spine with mild L3-L4 and L4-L5 central spinal canal stenosis. There was left L3-L4 perfacet edema possibly representing acute inflammatory arthropathy. The L5-S1 facet arthropathy resulted in anterolisthesis, disc uncovering and severe right and moderate left foraminal stenosis, contacting the exiting L5 nerve roots.

On June 24, 2013, reviewed the MRI findings and noted degenerative changes in the lumbar spine, facet arthropathy at L5-S1 with encroachment of spinal nerves. He prescribed Zanaflex and referred the patient for an orthopedic evaluation as there was no improvement with physical therapy (PT).

On July 12, 2013, an orthopedic surgeon, evaluated the patient for ongoing low back and left buttock pain which he experienced immediately after the injury. The patient stated that the pain had been persistent since that time and he had tried six sessions of PT and muscle relaxants but without any improvement. Examination showed reasonably good ROM for lumbar flexion and extension. reviewed the MRI of the lumbar spine and assessed left buttock radicular pain, lumbar spondylolisthesis at L5-S1 and lumbar spondylosis. felt that stated that the patient had started to improve over the last three months with PT and oral medications, given the radicular component. He felt that it was reasonable to go ahead and try an epidural steroid injection (ESI). He also discussed the other option of L4-S1 posterior decompression and fusion if the pain was uncontrolled.

On July 19,2013, noted worsening of the ongoing back pain after a walk two days ago. The patient continued to have pain with sitting and had radiation of pain. prescribed Ultracet and recommended light duty work and ESI.

On July 25, 2013, performed an ESI at L3-L4.

On August 8, 2013, saw the patient status post ESI. The patient reported that after three days his pain was worse than before. He had pain with sitting and walking and it radiated to the left side. On examination, the patient exhibited

decreased ROM. prescribed Vicodin and advised the patient to follow-up with a surgeon.

On August 22, 2013, noted the patient did not have any relief with the ESI. He examined the patient and assessed L4-L5 and L5-S1 foraminal stenosis with radiculopathy, L5-S1 spondylolisthesis and low back pain secondary to L4-L5 and L5-S1 foraminal stenosis with radiculopathy and L5-S1 spondylolisthesis. He discussed non-surgical and surgical treatment options including PT, deep tissue massage, acupuncture, chiropractic and use of inversion table and surgical options to include lumbar decompression and fusion at L4-L5 and L5-S1. The patient wanted to first try some other non-surgical things such as acupuncture prior to considering surgery. encouraged him to do that.

On the same date, the patient was evaluated. The patient reported that he was sleeping better and performing at light duty. He was interested in acupuncture/chiropractic treatment. therefore sent him for chiropractic evaluation and advised him to continue home exercise program (HEP) and light duty.

On September 23, 2013, noted that the patient's symptoms were about the same. He had not had any alternative treatment. advised him to continue seeing his spine surgeon and work with restrictions.

On September 23, 2013, computerized tomography (CT)scan of the heart was performed. It showed moderately abnormal study with total Agatston coronary calcium score of 100.91. The findings suggested a moderate degree of atherosclerotic plaque burden.

On September 27, 2013, the blood heavy metal panel showed high level of lead in the blood at 18.8. The lipid panel also showed high total cholesterol, triglycerides and LDL-cholesterol levels. The patient was advised to see his primary care physician (PCP). (The lead level in the blood was also noted to be at 15.7 on October 18, 2012.)

On September 30, 2013, noted that the patient did not have much relief with his PT, ESIs, acupuncture and chiropractic treatment. He therefore discussed the surgical options of transforaminal lumbar interbody fusion (TLIF) procedure at L5-S1 followed by L4 and L5 laminectomies with medial facetectomies and foraminotomies and posterior instrumentation and fusion. The patient wanted to wait for a while and consider it.

Per a note dated October 10, 2013, it was noted that the patient had been approved for acupuncture x8 to the low back.

Per utilization review dated October 14, 2013, the request for decompression of lumbar spine at L5-S1 level in addition to an L4 through S1 fusion with instrumentation was denied with the following rationale: *"I spoke to stated the claimant has spondylolisthesis at L5-S1, retrolisthesis at L4-L5, with foramina! stenosis at the lower two lumbar levels. However, the claimant has no objective*

physical exam findings consistent with radiculopathy. Based on essentially normal physical exam it would be very difficult to approve the requested procedure. The requested procedures do not meet guideline criteria and should not be certified. The physical examination findings and imaging study results do not support the surgical intervention that is being requested. Based on treatment guidelines, there must be significant segmental instability to support proceeding with a fusion at two levels. The claimant was noted to have some mild anterolisthesis of L5 on S1 on the MRI study, but there have not been any flexion and extension views to document whether this is a dynamic instability or just a stable instability noted on the MRI study. The claimant also has not undergone any psychological testing to see if the claimant is a good candidate for a fusion. There is no documentation of any instability or abnormal motion at the L4-L5 level to support the medical necessity of a fusion. The physical examination findings are also minimal with no significant evidence of a clinical radiculopathy to support the medical necessity of an L4 through S1 decompression and discectomy. Based on all the above factors, the request for an inpatient lumbar L5-S1 laminectomy, unilateral/bilateral, single segment (see order for additional) 63047, 22634, 22614, 22842, 20930, 22851 is not certified.”

Per reconsideration review dated October 25, 2013, the appeal was denied with the following rationale: *“Based on the clinical documentation, lack of specificity of pain generators, lack of clear cut objective radicular symptoms/size and lack of documentation of instability, the requested service are again denied. Official Disability Guidelines/Treatment Guidelines are not met.”*

Per the prospective IRO review response dated October 31, 2013, opined as follows: *“According to the spine treatment guideline, treatment of a work-related injury must be adequately documented and evaluated for effectiveness. As stated by the physician advisor, the request from the provider for a spondylolisthesis at L5-S1, retrolisthesis at L4-L5 with foraminal stenosis at the lower two levels with no objective physical exam findings consistent with radiculopathy as requested by does not meet the Official Disability Guidelines criteria. Per the ODG, clinical evidence of instability should be noted on examination in order to provide lumbar fusion. Current records have not provided flexion and extension views to document if there is a significant segmental instability to support proceeding with fusion at two levels. The provider also failed to provide any information of presurgical psychological screening as well prognosis of performing an interbody fusion in the patient who is not considered a surgical candidate per the ODG and basically with evidence of degenerative changes of the lumbar spine. Therefore, inpatient L4-S1, laminectomy, single segment/fusion as requested in a patient with essentially normal exam, lack of documentation of significant segmental instability, unknown failure of full exhaustion of conservative treatment and lack of performance of presurgical screening is not supported and is not medically reasonable or necessary at this time.”*

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

L4 through S1 laminectomy and L5-S1 fusion would not be considered medically necessary or appropriate in the records provided in this case and the Official Disability Guidelines. Official Disability Guidelines support lumbar decompression surgery to help treat lumbar stenosis resulting in symptomatic neurogenic claudication or symptomatic radiculopathy. Official Disability Guidelines support lumbar spine fusion in cases of spondylolytic spondylolisthesis, segmental instability objectively demonstrable on flexion/extension radiographs, fracture dislocation and progressive neurologic loss.

Records provided in this case document a degenerative L5-S1 spondylolisthesis. However, no records document an unstable spondylolisthesis with motion between the L5 and S1 segments on flexion/extension radiographs.

Examination in this case documents that reflexes, gait, and strength were normal, and therefore no radiculopathy problem is present. The history provided is vague. Buttock and leg pain are present and exacerbated by walking. This may be due to central stenosis or lateral recess stenosis. An MRI in this case demonstrates very mild central canal stenosis at multiple levels. There is no documentation of lateral recess stenosis. Therefore, absence convincing documentation of radiculopathy or neurogenic claudication, a decompression surgery would not be considered medically necessary or appropriate based upon the Official Disability Guidelines. Absent convincing documentation of an unstable L5-S1 spondylolisthesis with significant translation or rotatory instability noted between flexion/extension radiographs, an L5-S1 fusion cannot be certified in this case based upon the Official Disability Guidelines.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES