

Notice of Independent Review Decision

April 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-S1 laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator (inpatient-2 days)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Orthopedic Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work related injury on xx/xx/xx. The patient was rear-ended by a pick-up truck.

2013: On February 26, 2013, evaluated the patient for neck pain radiating into the arms. The patient also complained of right shoulder pain and low back pain that radiated into her legs and dizziness and headaches. The patient rated her pain at 9/10. Examination of the cervical spine showed muscle guarding/spasms with tenderness throughout the cervical spine. Range of motion (ROM) was restricted. Supine supported neck extension reproduced neck pain. There was a positive axial loading test and positive Spurling's and Max Compression test. Supine neck held against gravity produced neck pain. Examination of the right

shoulder showed taught and tender muscle fibers around the rotator cuff musculature. There was tenderness along the right acromioclavicular (AC) joint. There was limited right shoulder ROM. Prone upper extremity push up reproduced pain in the right shoulder. There was positive Hawkin's test, Neer's test and positive Apley's test. There was poor rotator cuff muscle strength supraspinatus 3-4/5 on manual muscle testing. Examination of the thoracic spine revealed muscle tightness and tenderness throughout the paraspinal musculature. Examination of the lumbar spine revealed tenderness in the lower segments, L4 and L5 over the facet joints. There was tenderness noted in the bilateral sacroiliac (SI) joint. There was muscle tenderness and tightness along the para lumbar musculature. Lumbar spine ROM was limited. Supine straight leg raise (SLR) was positive on the right at 60 degrees for lower back pain. Slump's test was positive. The patient had difficulty in getting into prone position from the supine position. obtained x-rays of the lumbar spine that showed advanced chronic multilevel degenerative facet arthropathy and disc space narrowing at L4-L5, L5-S1 and L2-L3 accompanied by small anteriorly projecting osteophytes at each of those levels. He diagnosed cervical spine sprain/strain, grade II, rule out herniated nucleus pulposus (HNP); lumbar spine sprain/strain, grade II, rule out HNP; thoracic spine sprain/strain, right shoulder sprain/strain, rule out internal derangement; cervicogenic headaches, articular dysfunction/biomechanical lesion of the cervical spine, articular dysfunction/biomechanical lesion of the lumbar spine and myalgia and myositis unspecified. recommended treatment to include therapeutic exercises, neuromuscular re-education, therapeutic activities and self care/home management instruction.

From March 14, 2013, through April 15, 2013, the patient attended chiropractic management under supervision.

On March 20, 2013, evaluated the patient for cervical spine pain radiating down bilateral shoulders and low back pain radiating down right leg. Examination of the cervical spine showed reduced ROM and diminished strength and tone due to head and neck pain. SLR was positive bilaterally at 40 degrees. Examination of the lumbar spine showed decreased ROM and diminished strength and tone due to pain. Mr. diagnosed back sprain/strain, neck sprain/strain and shoulder and lumbar arm sprain/strain. He prescribed Flexeril and Ultracet and recommended magnetic resonance imaging (MRI) of the cervical spine and lumbar spine.

On March 26, 2013, MRI of the lumbar spine showed disc protrusion/herniation measuring 4.8 mm at L3-T4 and 7.4 mm at L4-L5. There was ligament flavum and facet hypertrophy with spinal stenosis from L2 through L5.

On April 3, 2013, Mr. reviewed the MRI findings of the lumbar spine that showed disc herniation at L4-L5 and L3-L4. MRI of the cervical spine showed disc herniation at C5-C6 and C6-C7. Mr. recommended bilateral L4-L5 transforaminal epidural steroid injection (ESI) for pain control.

On July 8, 2013, performed lumbar transforaminal ESI.

On August 30, 2013, electrodiagnostic studies showed evidence of bilateral median sensory mononeuropathy of uncertain etiology. Clinical correlation was recommended. There was evidence of bilateral ulnar sensory mononeuropathy of uncertain etiology. Clinical correlation was recommended.

On November 5, 2013, noted the patient had been placed at maximum medical improvement (MMI) and was going to attempt to return to work the following week. The patient presented for surgical consultation for neck pain, arm pain, shoulder pain, low back pain and leg pain worse on the left than on the right. The patient had failed conservative treatment over the last approximately nine months. Examination of the neck and upper extremities revealed positive compression test, positive shoulder abduction test to the right, levator scapulae origin and midportion of trapezius on the right, negative Tinel's and Hoffmann's at both wrists and hypoactive biceps, brachioradialis and triceps jerks bilaterally and no gross motor deficits. Examination of the back and lower extremities revealed positive spring test, inter iliac crest line, positive extensor lag, positive sciatic notch tenderness bilaterally although worse on the left, negative Fortin finger test. There was positive flip test bilaterally, positive Lasegue's on the left at 45 degrees, positive Bragard's, absent posterior tibial tendon jerks bilaterally, hypoactive ankle jerks on the left and right with mild weakness of gastroc-soleus on the left and paresthesias in the L5 and S1 nerve distribution on the left. obtained x-rays of the lumbar spine that showed functional spinal unit collapse of 3 mm at C4-C5 and of 4 mm at C5-C6 and 4 mm of C6-C7. diagnosed internal disc disruption syndrome with clinical instability cervical and lumbar spine with failure of conservative treatment. The patient understood that she was a surgical candidate for her discogenic pain, but to delineate the pain generators provocation discography and post-discographic computerized tomography (CT) scan would be the best test to evaluate that.

On November 6, 2013, reviewed the MRI scan findings of the cervical spine that showed: At C4-C5, disc herniation rated at stage II with annular herniation, nuclear protrusion and spinal stenosis. At C4-C5, C5-C6 and C6-C7, non-contained disc herniation rated at stage III with annular herniation, nuclear extrusion, disc desiccation consistent with T2-weighted image changes and spinal stenosis. MRI of the lumbar spine revealed L5-S1 residual disc, L2-L3, L3-L4 and L4-L5 non contained disc herniation rated at stage III with annular herniation, nuclear extrusion, disc desiccation consistent with T2-weighted image changes and spinal stenosis.

On December 11, 2013, the patient had called. The patient stated that she was in so much pain that she wanted to proceed with scheduling surgery.

On January 13, 2014, performed a pre-surgical evaluation. The patient's Beck Depression Inventory II (BDI-II) and Beck Anxiety Inventory (BAI) were in a moderate range reflecting a moderate experiencing of various symptoms of depression and anxiety. Those moderate emotional stressors were mostly likely due to the chronic nature of the patient's pain and his want to recover and return

to work. The patient was able to undergo any surgical/spinal intervention which was found necessary for the success of patient's recovery.

Per utilization review dated February 21, 2014, the request for L2-S1 laminectomy, discectomy, fusion and instrumentation, implantable bone growth stimulator (inpatient two days) was denied based on the following rationale: *"The requested L2 to S1 laminectomy, discectomy and fusion with instrumentation is not recommended as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The imaging studies do show multileveled degenerative disc disease. There was some evidence of lateral recess stenosis to the right at L4-L5 and bilateral lateral recess stenosis at L3-L4. Electrodiagnostic studies were negative for any evidence of radiculopathy. On physical examination, the patient reported paresthesia in a left L5-S1 distribution with mild gastroc weakness to the left side which does not correlate with imaging. The patient has been requested for an L2 to S1 decompression and fusion; however, the clinical documentation does not specifically identify the patient's pain generators. Furthermore, opined that there was clinical instability in the lumbar spine on radiographs; however, no radiographic reports were available for review identifying any motion segment instability at any level from L2 to S1. The clinical documentation and case notes also indicate that the patient had been recommended for a chronic pain management program. Given this recommendation for a tertiary level chronic pain management program, it is unclear whether the patient would overall have any substantial benefit from a multi-level lumbar fusion procedure at this time. As the surgical requests for this patient are not supported as medically necessary, the requested implantable bone growth stimulator and a two day inpatient stay would not be medically necessary at this time."*

Per reconsideration review dated March 03, 2014, denied the appeal for L2-S1 laminectomy, discectomy fusion and instrumentation, implantable bone growth stimulator (inpatient-two day) based on the following rationale: *"The only clinical information I am asked to review includes a prior non-authorization review opinion, a "Pre-Authorization Request" form, and my peer to peer telephone conversation. I have no office records. According to the information I have been asked to review, female who sustained injuries in a motor vehicle accident on xx/xx/xx, developing complaints of pain in the mid and lower back. She has had previous physical therapy treatments and a work hardening program. Radiographs on February 26, 2013, reportedly reveal moderate multi-level degenerative changes, most pronounced at L5-S1, though there is no radiology report contained in the record set. This information comes from the report. This information also indicates there is no evidence of subluxation or motion segment instability. Also revealed in this report are MRI findings from March 26, 2013, that reveal mild disc height loss at L2-L3 with Modic end plate changes with mild retrolistheses. L3-L4 reveals moderate disc height loss with a 4.8 mm right posterolateral disc protrusion that along with facet hypertrophy causes canal and lateral recess stenosis. At L4-L5, there is moderate disc height loss and Modic end plate changes and minimal retrolisthesis along with a 7.4 mm disc protrusion leading to lateral recess stenosis and moderate canal stenosis. At L5-S1, there is*

a "cone shaped" L5 vertebral body with no mention of disc herniation or stenosis. An EMG study in August 2013 revealed no radiculopathy. According to report, reported functional spinal collapse at L4-L5 and L5-S1 of 10 mm and 13 mm respectively. There was a positive Lesegue's sign on the left at 45 degrees and hypoactive reflexes were noted bilaterally with mild weakness of the gastroc-soleus. Paresthesia was noted in the L5-S1 distribution. A psychological evaluation from January 13, 2014, revealed moderate depression without anxiety and there was no contraindication for surgery. In my conversation on February 28, 2014, he indicated the patient had no spondylolisthesis at any level. His description of the functional spinal unit collapse alluded to in report is the amount of disc space loss compared to a normal level. As a consequence of this disc space loss and the facet hypertrophy indicated to me the patient had severe, "pin hole" foraminal stenosis bilaterally at these two levels. stated to me that it would be impossible to decompress this stenosis without removing a substantial portion of each facet joint at each level on each side necessitating the fusion of L4-S1. The remainder of the requested surgical levels L2-S1 require decompression in the form of laminectomy and discectomy. He also requests an implantable bone growth stimulator. The "pre-authorization request" form submitted is clear in that the requested procedure includes "L2-S1 laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator." In addition, description of the degree of stenosis present in this case is in opposition to the information in report. Admittedly, there is no radiologists report for me to review, however under the circumstances, the information conflicts to such a degree that there is insufficient medical evidence to support authorizing the requested procedure of L2-S1 laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator."

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

L2-S1 laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator (inpatient-2 days) would not be considered medically necessary in based on the records provided and the Official Disability Guidelines. The claimant has lumbar spondylolisthesis with stenosis. Electrodiagnostic studies were performed which demonstrated no evidence of radiculopathy. No convincing records have been provided which document any type of instability. The Official Disability Guidelines support

lumbar spinal fusion for cases of neural arch defect such as spondylitic, spondylolisthesis, segmental instability or a one to two level segmental failure of the functional spinal unit with collapse of disc space. In this case there is no evidence of instability and a four level fusion has been requested. For the reasons stated above L2-S1 laminectomy, discectomy, fusion with instrumentation, implantable bone growth stimulator (inpatient-2 days) would not be certified in this case.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES