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Notice of Independent Review Decision

August 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One complete laminectomy and facetectomy at L2-L4 with pedicle screw fixation and lateral mass fusion; intraoperative monitoring with two-day inpatient stay.

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:

Overturned (Disagree)

Medical documentation supports 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who fell on xx/xx/xx, falling and injuring his lower back and neck.

On November 26, 2012, evaluated the patient for review of computerized tomography (CT) myelogram. The patient complained of bilateral leg pain. He had some stenosis at L3-L4 specifically severe lateral recess stenosis on the left. Examination revealed grade 4 motor power in the quadriceps bilaterally, diminished knee jerks, dysesthesias in the L3 and L4 nerve root distribution and femoral nerve distribution bilaterally. recommended selective nerve root block at the L3 nerve root bilaterally.

On November 26, 2012, refilled Roxicodone.

On December 6, 2012, performed bilateral selective nerve root block at L3-L4. On December 20, 2012, performed lumbar epidural steroid injection (ESI) with epidurogram.

On February 18, 2013, noted dramatic sustained improvement from the ESI. Pain was gradually beginning to recur. The patient was beginning to experience radicular complaints down both legs. He had equivocally positive straight leg raising (SLR) bilaterally from a seated position, decreased range of motion (ROM) in the lumbar spine and lumbar paravertebral muscle spasm and tenderness. recommended repeat lumbar ESI.

On March 7, 2013, performed lumbar ESI with epidurogram.

On April 16, 2013, noted usual partial relief of discomfort. The patient continued with low back pain which radiated into the legs on the basis of failed back syndrome/post-laminectomy syndrome. He was reluctant to proceed with more aggressive treatment such as spinal cord stimulator (SCS), he had these in the past with mixed results. Examination findings were unchanged. refilled oxycodone.

On June 13, 2013, a neurosurgeon, noted progressive problems with the low back. The patient had a 360 two-level fusion L4 through S1 as well as a two level anterior cervical discectomy and fusion. He did well initially after his surgeries. Because of the progressive problems a spinal stimulator was placed several years ago. He had multiple intervening lumbar ESIs over the past several years. He presented with CT myelogram of the lumbar spine that showed significant adjacent segment disease and stenosis with spondylolisthesis at the un-operated L3-L4 level. The patient reported that his legs intermittently gave way. He also had chronic back and bilateral leg pain and requested surgical opinion. Examination revealed mildly antalgic gait, straight leg raising (SLR) at 60 degrees on the left and -1 deep tendon reflexes (DTRs) in the lower extremities. assessed lumbar spinal stenosis syndrome with grade 1 spondylolisthesis at L3-L4 and recommended posterior lumbar decompression and interbody fusion.

On June 20, 2013, reviewed CT myelogram performed in December 2012 that showed a grade 1 spondylolisthesis and collapse of the segments at L2-L3 and L3-L4 with significant lateral recess stenosis as well as AP canal diameter down to 8 and 9 mm respectively.

On July 19, 2013, the patient underwent a psychiatric diagnostic evaluation. The evaluators opined that the patient was psychologically able to proceed with the lumbar posterior decompression and interbody fusion at L2-L3 and L3-L4 with pedicle screw fixation.

On April 15, 2014, CT scan of the lumbar spine revealed a 1-2 mm retrolisthesis of L2 on L3 and L3 on L4, a bony union at L4-L5 and L5-S1 along the lamina/facet region and also across the disc space. There was osteophyte formation and

bulging at L2-L3 with 25% spinal canal stenosis. There was 50% foraminal narrowing seen at L2-L3 and L3-L4.

On April 24, 2014, the patient was evaluated. The patient was eight months status post decompressive laminectomy L2 through L4. The patient complained of increasing back pain and pain and numbness on both sides. Examination revealed absent knee jerk on the right and a diminished left ankle jerk. SLR and femoral stretch reproduced bilateral thigh pain. ordered flexion and extension x-rays and CT myelogram of the lumbar spine.

On May 15, 2014, flexion and extension x-rays of the lumbar spine revealed a 2-mm retrolisthesis of L2 on L3 that increased to 4 mm on extension, 2 mm retrolisthesis of L3 on L4 that increased to approximately 3.5 to 4.0 mm on extension, suggestion of 3 mm of retrolisthesis of L4 on L5, central canal stenosis at L2-L3, suggestion of slight central canal narrowing at L3-L4, decompressive laminectomy at L3 and L4.

Fluoroscopic interpretation of the lumbar spine dated May 15, 2014, showed retrolisthesis of L2 on L3 and L3 on L4, disc space narrowing at L2-L3 and L3-L4, interbody fusion at L4-L5 and L5-S1 and L3 and L4 decompressive laminectomy.

On May 15, 2014, a CT myelogram of the lumbar spine showed status post L4-L5 and L5-S1 interbody fusion, status post L3 and L4 decompressive laminectomy, retrolisthesis of L2 on L3, L3 on L4, L4 on L5 and severe L2-L3 and L3-L4 disc space narrowing with vacuum discs, L2-L3 spinal stenosis with effacement of the anterior and posterior CSF space, secondary to broad based disc bulge, retrolisthesis and endplate spurring and multilevel neural foraminal narrowing with multilevel nerve root impingement.

On May 29, 2014, reviewed the diagnostic studies. Examination revealed a mildly antalgic gait, SLR was bothering mostly in the left leg at 60 degrees and DTRs were -1 and symmetric in the lower extremities. diagnosed lumbar spinal stenosis syndrome with grade 1 spondylolisthesis L2-L3 and L3-L4. He opined that the patient was a candidate for revision surgery to include complete laminectomy and facetectomy L2 through L4 with pedicle screw fixation and lateral mass fusion. The patient had failed additional conservative management given to him since his surgery eight months ago which included multiple ESIs as well as ample physical therapy (PT).

On June 5, 2014, the patient followed-up after selective nerve root block performed three weeks ago which ceased his radicular complaints completely. He still complained of low back pain, paravertebral muscles spasm and tenderness. Examination of lumbar spine showed decreased ROM and positive SLR test. recommended surgical approach to onset of new disc pathology at the L2-L3 level (this was above the area of previous surgery). refilled Naprosyn. The patient had adequate hydrocodone for breakthrough pain currently. prescribed Roxicodone to be filled next week since it had only been three weeks since his last prescription.

Per utilization review dated June 9, 2014, the request for complete laminectomy and facetectomy at L2-L4 with pedicle screw fixation and lateral mass fusion, intraoperative monitoring with 2-day inpatient stay was denied with the following rationale: *“This is a male who was injured on xx/xx/xx. A CT myelogram of the lumbar spine was obtained on May 15, 2014. This imaging study documents retrolisthesis of L2 on L3 and L3 on L4. Additionally, the claimant is noted to be status post interbody fusion at L4-S1. The retrolisthesis is noted to be 4 mm at L2-L3 with extension and 3.5 to 4 mm with extension at L3-L4. The most recent clinical document dated May 29, 2014, indicates that the injured worker is 8 month status post decompressive laminectomy at L2-L4. Within the last 2 months the injured worker is noted to have increasing complaints of back pain and numbness in both thighs. New findings on examination include absent knee jerk on the right and a diminished ankle jerk on the left. There is no focal motor weakness and SLR and femoral stretch reproduced bilateral thigh pain. The clinician indicates that whether or not the injured worker can be improved by the additional surgery is unclear if the claimant has undergone multiple conservative measures since the prior operative intervention including ESIs and PT.”*

Per reconsideration review dated June 16, 2014, the appeal for reconsideration was denied based on the following rationale: *“The previous non-certification is supported. Additional records were not provided for review, Official Disability Guidelines - Treatment in Workers' Compensation would support lumbar fusion in the management of low back pain and residual radiculopathy in settings of excessive instability sometimes seen in spondylolisthesis. There must be spinal instability of greater than 4.5 mm. The CT myelogram noted 3.5 to 4.0 mm of instability with no notation of progression of neurological deficits in the records. The psychological clearance was performed in July 2013 with no more recent evaluation provided for review. The request for reconsideration of a complete laminectomy and facetectomy at L2-L4 with pedicle screw fixation and lateral mass fusion; intraoperative monitoring, as well as a 2-day inpatient stay are not certified.”*

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

The claimant is a gentleman who's had chronic lumbar complaints, appropriate non-surgical and thorough treatment for greater than six month period of time. Flexion and extension radiographs demonstrate a retrolisthesis of L 2 on L 3 and L 3 on L 4 which changed dynamically the flexion and extension positions. Due to the appropriate non-surgical treatment, due to the instability documented and fusion at this level, it is reasonable and appropriate. Official Disability Guidelines were referenced. Intraoperative monitoring and a two day stay following a two level fusion is 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