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Notice of Independent Review Decision

September 29, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-L4 mini 360 fusion

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:

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had an injury on xx/xx/xx. He was involved in a motor vehicle accident (MVA) where he was rear-ended traveling at 40-45 miles per hour. He started with an acute onset of back pain and right shoulder pain.

2013: Per a questionnaire dated December 30, 2013, the patient complained of lower back pain, numbness in right leg and right shoulder stiffness and weakness. He rated the pain at 8-10/10 in intensity. The pain was stabbing, tingling, numb and radiating in quality. The pain radiated to the lower back. He had associated localized tingling, sleep disturbance, frontal headaches, difficulty walking and muscle spasm. The pain varied depending on activity and exacerbated his condition. He had occasionally ribcage pain and knee pain. He stated nothing would help. He was utilizing Adderall and Centrum. The history was remarkable for ADD, tonsil surgery and left shoulder surgery in 2011. The patient was

recommended magnetic resonance imaging (MRI) of the lumbar spine and recommended chiropractic therapy.

From December 30, 2013, through April 17, 2014, the patient underwent multiple chiropractic therapies with modalities to include interferential muscle stimulation, intersegmental traction and adjustments.

On December 31, 2013, MRI of the lumbar spine revealed at L3-L4, there was broad-based posterior central and bilateral foraminal 2-3 mm disc protrusion without impingement, early developing spondylosis and facet arthropathy. At L2-L3, there was facet joint effusion bilaterally without hypertrophy or articular erosion, nonspecific, and might result from any inflammatory joint disease or might be posttraumatic.

2014: On February 27, 2014, evaluated the patient for severe back pain radiating to bilateral lower extremities, bilateral foot numbness and weakness in the right leg. He was utilizing hydrocodone and Flexeril. Examination revealed that he was sitting uncomfortably. He had difficulty acquiring a full upright position when getting out of the chair. His gait was slow and purposeful. The gait was antalgic to the right. The right quadriceps and right tibialis anterior strength was 4/5. He was guarding the right upper extremity secondary to recent right shoulder surgery. X-rays of the lumbar spine revealed lytic spondylolisthesis at L3-L4 and loss of disc height identified at L5-S1. MRI of lumbar spine revealed affected levels to be L3-L4 with disc desiccation and spondylolisthesis. diagnosed lumbosacral neuritis/radiculitis unspecified and lumbosacral region spondylolysis. The patient was recommended lumbar epidural steroid injection (ESI) and continuing current conservative care.

On May 23, 2014, performed caudal epidural steroid injection, caudal intra-spinal myelograph without dural puncture, myelographic interpretation and conscious sedation.

On June 6, 2014, saw the patient status-post spinal injection. He noted the injection was unsuccessful. The patient still had difficulty with back pain and bilateral leg pain worse on the right and then on left. He had difficulty with ambulation. The pain was severe and affecting the quality of life. opined that the patient was a candidate for L3-L4 spinal fusion and prescribed Tylenol with codeine.

On July 19, 2014, performed a behavioral medicine evaluation for pre-surgical psychological screening for mini 360 fusion at L3-L4. The patient's pain and impairment relationship scale (PAIRS) score was 80 placing him the moderate-high range indicating some sense of demoralization. He scored 15 on the CBS-D suggesting mild depression. He scored 21 on BAI suggesting moderate anxiety. He scored 11 on COMM suggesting moderate potential for aberrant medication taking behavior. The diagnosis was major psychological symptoms to include mild adjustment issues of some anxiety and depressive affect and sleep disturbances. Mr. opined that the psychosocial issues should not impact the result of surgery. The patient was taking very limited medications and had a

strong health engagement history. No psychological treatment was needed at the present time. Based on this pre-surgical psychological screening, the patient was cleared for surgery with a fair-to-good psychosocial prognosis for pain reduction and functional improvement.

Per utilization review dated July 8, 2014, the request for L3-L4 mini 360 fusion with two-day inpatient hospital stay was denied with the following rationale: *“The claimant is a male, who was injured on xx/xx/xx, in a motor vehicle accident. The claimant was diagnosed with lumbar disc displacement. Medications included Tylenol with codeine and other non-steroidal anti-inflammatories. A previous shoulder surgery was performed on February 3, 2014. An MRI of the lumbar spine on December 31, 2014, documented an L4 broad-based central bilateral foraminal 2-3 mm disc protrusion without impingement. There was early development of spondylosis and facet arthropathy. At L3-L4, there was facet joint fusion bilaterally without hypertrophy or articular erosion. Treatment had included an epidural steroid injection at L3-L4 on May 23, 2014, and physical therapy. A psychological clearance on June 19, 2014, documented clearance for surgery. An evaluation on June 6, 2014, documented complaints of low back and bilateral leg pain. There was 4/5 right quadriceps and anterior tibialis strength. There was no hyperreflexia and no clonus. There was an abnormal gait favoring the right leg. Tension signs on the sciatic nerve on the right side were noted. Official Disability Guidelines Treatment in Workers Compensation does not support lumbar fusion without lumbar instability. There are no flexion/extension films documenting any lumbar instability. The records do not reflect radiculopathy with muscle atrophy or loss of relevant reflex. The records do not reflect lower levels of care including a home exercise program, muscle relaxants, or upper extremity of oral steroids. The request for an L3-L4 mini 360 fusion with two day inpatient length of stay is not certified.”*

Per reconsideration review dated August 25, 2014, the appeal for L3-L4 mini 360 fusion with two-day inpatient hospital stay was denied with the following rationale: *“This is a reconsideration of a previously non-certified request for an L3-L4 mini 360 degree fusion with two-day inpatient hospital stay. The claimant is a male who was injured on xx/xx/xx, in a motor vehicle accident. The claimant was diagnosed with lumbar disc displacement. The claimant was treated conservatively with medication management including anti-inflammatory medications and Tylenol with codeine. An MRI of the lumbar spine was performed December 31, 2014, which documented at L4 a broad-based central bilateral foraminal 2-3 mm disc protrusion without impingement with early development of spondylosis and facet arthropathy. At L3-L4 there was facet joint fusion bilaterally without hypertrophy or articular erosion noted. The claimant underwent an epidural steroid injection at L3-L4 on May 23, 2014, along with physical therapy. The claimant underwent a psychological evaluation on June 19, 2014, and was cleared for surgery. A physical examination performed on June 19, 2014, documented low back pain and leg pain with numbness and weakness in the legs. The pain was rated 10/10 at its worst on the visual analog scale and 8/10 at its least. The injured employee was cleared for surgery in a psychological examination on June 6, 2014. The physical examination documented low back pain with bilateral leg pain. The back pain was worse on the right than the left.*

There was 4/5 strength in the right quadriceps and anterior tibialis. No hyperreflexia and no clonus were observed. There was an abnormal gait favoring the right leg. The claimant was noted to be a candidate for an L3-L4 spinal fusion to address traumatic spondylolisthesis with a pars fracture that was symptomatic with failure of conservative treatment. The examination of February 27, 2014, reported AP flexion and extension lumbar x-rays indicated lytic spondylolisthesis at L3-L4 with no significant scoliosis or compression fractures with loss of disc height identified at L5-S1. An MRI report of December 31, 2013, documented at L3-L4, there was a broad-based posterior central 2-3 mm disc protrusion seen effacing the epidural space without displacement of the descending L4 roots or impingement upon the exiting L3 nerve roots. There was slight disc dehydration with minimal anterior endplate spondylosis and minimal facet hypertrophy with a low grade joint effusion noted. This is a non-certification of a reconsideration request for an L3-L4 mini 360 degree fusion with two-day inpatient hospital stay. The previous non-certification on July 8, 2014, stated that the documentation did not support lumbar instability. It was noted that there were no flexion/extension films documenting any lumbar instability, that there were no records to reflect radiculopathy with muscle atrophy or loss of relevant reflex, and that no records reflected lower levels of care including a home exercise program, muscle relaxers, or the use of oral steroids. No additional records were provided for the reconsideration process to support the medical necessity of the request. The previous non-certification is supported in that flexion/extension x-rays are not objectively and independently verified noting lumbar instability. There is stated to be lysis of the pars at L3-L4. The grade of instability is not documented or objectified by an independent radiologist. There is no objectified clinical radiculopathy of the right lower extremity, only 4/5 strength in the quadriceps and anterior tibialis with no relevant loss of reflex, muscle atrophy, or sensory deprivation. Without objectified lumbar instability with independent reading, the request is not supported as peer review guidelines state that lumbar fusion is indicated for neural arch defect or segmental instability objectified by diagnostic imaging, by x-rays demonstrating spinal instability and/or myelogram, CT myelogram, or discography. The reconsideration request for an L3-L4 mini 360 degree fusion with two-day inpatient hospital stay is not certified."

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

In this case this individual is status post injuries sustained in a motor vehicle accident. There is no documentation that flexion/extension x-rays were done and there is no indication within the record of instability. On MRI the findings were of early developing spondylosis and facet arthropathy at L3-4 and no indication of a neural compressive lesion. Examination findings have been notable for strength graded at 4/5 but beyond that there is not any documentation of a sensory or reflex deficit, and the examination is not consistent with radiculopathy. Absent evidence of a neural arch defect or segmental instability, the guideline criteria are not satisfied and as such the medical necessity for the requested L3-4 mini 360 degree fusion is not established.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES