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Notice of Independent Review Decision

March 9, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
ALIF L5-S1 with posterior lumbar decompression to include bilateral facetectomies

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured at work on xx/xx/xx. The patient fell off a truck and hit his back on the tire of a forklift and then landed on the ground. He suffered an acute onset of primary low back pain with radiation into the right lower extremity along the lateral thigh and calf and into the lateral aspect of the right ankle with intermittent numbness and tingling.

X-rays of the lumbar spine were performed on April 28, 2014. There was a grade 2 spondylolisthesis at L5-S1 with marked L5-S1 discogenic disease and fracture of the transverse process of L3 on the right.

A computerized tomography (CT) scan of the lumbar spine on May 19, 2014, demonstrated a grade 2 spondylolisthesis of L5 on S1 with bilateral pars

interarticularis defects and fractures of the transverse process of L1 and L2 vertebral body on the right.

a neurosurgeon, evaluated the patient on June 3, 2014, for low back pain rated as 2/10 with worsening pain on sitting and standing. Lumbar range of motion (ROM) was slightly decreased in forward flexion secondary to pain. There was 4/5 strength of gastrocnemius and biceps femoris on the right. The patient had difficulty with toe walking. Straight leg raising (SLR) test was positive at 40 degrees on the right. The diagnoses were lumbar radiculopathy (rule out herniated nucleus pulposus) and spondylolysis and spondylolisthesis at L5-S1, grade 1 to 2 with pars defects at L5 bilaterally. recommended initiating physical therapy (PT), obtaining flexion-extension views and magnetic resonance imaging (MRI) of the lumbar spine and evaluating for epidural steroid injection (ESI).

An MRI of the lumbar spine on June 18, 2014, demonstrated: A 7-mm anterolisthesis of L5 over S1 secondary to bilateral pars interarticularis defect combined with pseudobulge and moderate bilateral facet osteoarthritis resulting in severe bilateral neural foraminal stenosis with mass effect on the exiting L5 nerve roots bilaterally, and multilevel and multifactorial lumbar spondylosis at the remainder of the levels resulting in mild neural foraminal stenosis at several levels. Additionally, at L2-L3 a right lateral disc bulge closely approximated the right exiting L2 nerve root. X-rays showed disc degeneration and 12-mm grade 1 spondylolisthesis at L5-S1 that was stable with flexion and extension. Bilateral L5 pars defects were suspected.

The patient underwent 19 sessions of therapy from June 24, 2014, through October 17, 2014. The modalities included manual therapy techniques, neuromuscular reeducation and therapeutic activities/exercises.

On August 29, 2014, the patient underwent an ESI at L5-S1 via a caudal approach.

In a follow-up on October 13, 2014, the patient reported no significant improvement in the previous symptomatology. Lumbar ROM was decreased in forward flexion, gastrocnemius and biceps femoris muscle strength was 4/5, and SLR was positive on the right and negative on the left. There was a hypoesthetic region over the S1 distribution on the right to pinprick and light touch. Due to failure of conservative therapy, recommended anterior lumbar interbody fusion (ALIF) at L5-S1 with posterior lumbar decompression and posterolateral fusion and pedicle screw instrumentation.

The patient underwent a behavioral health evaluation on November 24, 2014, in which he scored 12 on physical activity and 30 on the work scale of the Fear Avoidance Beliefs Questionnaire; 36 on the Beck Depression Inventory and 19 on the Beck Anxiety Inventory. The diagnoses were chronic pain disorder with psychological features and a general medical condition; severe psychological stressors and GAF of 60. The patient was cleared for surgery.

On December 15, 2014, the patient underwent right shoulder arthroscopic subacromial decompression and acromioplasty, debridement of labrum, open rotator cuff repair and micro-tenotomy of the rotator cuff.

Per a utilization review dated 12/31/2014, the request for ALIF at L5-S1 with posterior lumbar decompression, posterolateral pedicle screw instrumentation, co-surgeon and length of stay for two days was denied with the following rationale: *"The patient's most recent x-ray examination from 06/18/2014 indicated the patient was stable with flexion and extension; however, the patient would not be considered as having any instability regarding his lumbar spine. Therefore, although the patient does have a noted spondylolisthesis at L5-S1 and had plateaued in his PT, it was clear from a psychological standpoint, it was further noted in the requested CPT codes that the request for 2612 is not approved as an authorized treatment. The Prior Authorization Request form from 12/16/2014 has the same number represented with no indication as to what this represents. Therefore, with the patient not meeting the criteria for the requested ALIF with posterolateral fusion, pedicle screw instrumentation and co-surgeon, as well as two days length of stay, the request in its entirety cannot be supported without having verification of the CPT code 2612 was a typo. Additionally, the patient did not have instability noted on flexion or extension views to warrant the requested surgery at this time. Therefore, after peer to peer conversation, the request remained non-certified."*

evaluated the patient status post right shoulder arthroscopic surgery. There was tenderness over the proximal humerus and over the bicipital groove and biceps. Staples were removed and the patient was advised to initiate early passive range of motion (ROM) and progress towards active ROM.

On January 6, 2015, removed the remaining staples and referred the patient for postoperative PT.

On January 26, 2015, the appeal for ALIF at L5-S1 with posterior lumbar decompression and posterolateral fusion with pedicle screw instrumentation, co surgeon and length of stay for two days was denied with the following rationale: *"While the patient complains of low back symptoms, there is no recent comprehensive clinical evaluation of the patient from the treating physician that addresses the proposed surgery considering that the last evaluation submitted was on October 3, 2014. In agreement with the previous determination, the medical necessity of the request has not been substantiated."*

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

This claimant had a work incident on xx/xx/xx, when he fell from a truck approximately five feet and struck his back on tire of a forklift. He had low back pain with radiation to the right side and knee area.

The patient had x-rays taken of the lumbar spine on April 28, 2014, noting a grade II spondylolisthesis of L5 on S1 with discogenic changes at that level and of L3 transverse process fracture. A CT scan was completed on May 19, 2014, showing a grade II spondylolisthesis with bilateral pars defects and transverse process fracture of L1 and L2 on the right.

evaluated the claimant on June 3, 2014, with pain of the low back at 2 on a 10 scale. The patient was reported to have 4/5 strength in the gastrocnemius on the right and some difficulty with toe walking but the straight leg raise was reported positive at 40 degrees on the right, negative on the left. The diagnosis included spondylolysis and spondylolisthesis. proposed physical therapy, flexion-extension x-rays, and an MRI of the lumbar spine and possible epidural steroid injection.

The lumbar MRI was completed on June 18, 2014, showing anterolisthesis of L5 on S1 with a pseudo bulge at L5-S1. There was also facet arthrosis causing narrowing of the neural foramen with some mass effect towards the L5 nerve roots bilaterally. There was also a right L2-L3 lateral disc bulge. Patient did have x-rays taken with flexion extension which did not show instability per the report. The patient did undergo formal physical therapy with Select Physical Therapy for 19 sessions and also underwent an epidural steroid injection by caudal approach with catheter on August 29, 2014, with some benefit reported. The patient was reassessed on October 13, 2014. The patient was reported to have hypoesthesia over the S1 distribution on the right. The patient was also reported to have gastrocnemius muscle strength of only 4/5.

The patient did have a psychological assessment and was cleared for surgery.

On January 26, 2015, there was an appeal for the surgical procedure of ALIF at L5-S1 with posterior lumbar decompression, posterolateral fusion with pedicle instrumentation after the initial request had been denied through utilization review. The second review concurred that the patient did not have instability and that the patient thus would not warrant the operative intervention that was proposed.

Summary:

This patient has a developmental condition of his lumbar spine with the spondylolisthesis with bilateral pars defects. He has noted degenerative signal in the L5-S1 with the Modic endplate changes as well as vacuum phenomenon. The patient's neurological exam allegedly showed that the patient has an S1 type deficit however, the neural foramen are narrowed with mass effect towards L5. However, there was no specific neurological deficit identified for the L5 nerve root. The disc at L5-S1 is a pseudobulge.

Given that there is no instability except for the intrinsic spondylolisthesis which is not related to the work incident and that there is no specific neurological deficit objectively then the request for surgical intervention to include the fusion procedure which would only be necessary for spine instability would not be warranted as a medical necessity by ODG criteria.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**