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Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

360 degree fusion at L4-L5 and L5-S1:

- **63090**: Vertebral corpectomy, partial or complete, with decompression of spinal cord, lumbar, single segment
- **63091**: Vertebral corpectomy, partial or complete, with decompression of spinal cord, lumbar, each additional segment
- **22558**: Anterior lumbar fusion
- **20931**: Spinal bone allograft
- **22612**: Posterior lumbar fusion
- **22851**: Application of spinal prosthesis

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

The physician providing this review is a spinal neurosurgeon. The reviewer is national board certified in neurological surgery. The reviewer is a member of the American Association of Neurological Surgeons, The Congress of Neurological Surgeons, The Texas Medical Association, and The American Medical Association. The reviewer has been in active practice for 38 years.

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 360 degree fusion at L4-L5 and L5-S1

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance

- Utilization reviews (02/01/08 – 02/12/08)

Insurance

- Office notes (09/25/07 – 01/28/08)
- Diagnostics (08/15/07 - 12/26/07)
- Utilization reviews (02/01/08 – 02/12/08)

M.D.

- Office notes (09/25/07 – 01/28/08)
- Diagnostics (08/15/07 - 12/26/07)
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- Diagnostics (08/15/07 - 12/26/07)
- Utilization reviews (02/01/08 – 02/12/08)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who slipped and fell and injured his lower back.

In August, magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) small-to-moderate sized broad-based right lateral herniated nucleus pulposus (HNP) at L5-S1 causing mild compression of the anterolateral recess and foramen. (2) Much smaller left lateral HNP at L4-L5.

D.O., suggested consideration of spinal surgery as the patient was not better with conservative care. M.D., a neurosurgeon, evaluated the patient for low back and right leg pain and numbness. The patient had a back injury but it was nothing compared to this. On examination, sitting root test and straight leg raise (SLR) test were productive of low back and posterior thigh pain. Sensation was diminished over the lateral aspect of the right calf. There was slight weakness of the right extensor hallucis longus (EHL). In a psychological evaluation, the patient was diagnosed with adjustment disorder with mixed emotional features and opioid medication dependence (in remission).

A lumbar discogram produced moderate concordant pain at L4-L5 and severe concordant pain at L5-S1. X-rays revealed degenerative discs at these levels. Dr. recommended either a two-level disc replacement or fusion surgery. The patient turned down the option of artificial disc placement; hence, fusion surgery was requested by Dr.

On February 1, 2008, the request for 360–degree fusion was nonauthorized with the following rationale: *Based on the clinical information provided, the request for 360-degree fusion at L4-L5 and L5-S1 with two-day length of stay is not recommended as medically necessary. The patient injured his low back due to a slip and fall. The patient is noted to have failed extensive conservative care, but there is no comprehensive history of treatment to date. MRI is noted to have been completed in August 2007, but no radiology report was submitted for review. Discogram was positive at L4-L5 with moderate concordant pain and*

severe concordant pain at L5-S1. The patient underwent a psychological evaluation on December 5, 2007, and was noted to have become addicted OxyContin after this injury and underwent a six-week inpatient detox. He also has a prior history of substance abuse. The patient was noted to have no evidence of pain sensitivity or symptom magnification and was cleared for discogram and potential spine surgery. Noting that there is no evidence of lumbar spine instability or spondylolisthesis, the proposed lumbar fusion is not indicated as medically necessary.

A reconsideration request for the fusion surgery was non-authorized with the following rationale: *Based on the information provided as well as the dependency of discography to predict fusion outcome surgery, the request is inconsistent with evidence-based guidelines as noted below. Phone conversation will be necessary with the requesting physician to discuss these issues. Spinal fusion is sometimes considered in the treatment of a painful spinal condition without clear indications of instability. A major obstacle to the successful treatment of spine pain by fusion is the difficulty in accurately identifying the source of patient's pain. Unfortunately, current techniques to precisely identify which of the many structures in the spine that could be the true source of patient's back or neck pain have not been perfected. The limits in our ability to accurately identify the painful structure make treatment of back or neck pain alone by spinal fusion very controversial. Fusion under these conditions is usually viewed as a desperate last resort and should be considered with limited optimism. The most recent online version of ODG suggests: <u>not recommended for patient's who have less than six months failed conservative care unless there is severe structural instability and/or acute or progressive neurologic dysfunction.</u> According to the recently released AANS/NASS guidelines<u>: lumbar fusion is recommended as a treatment for carefully selected patient's with disabling low back pain due to one or two level degenerative disc disease (DDD) after failure of an appropriate period of conservative care.</u> A recently published well-respected internal guideline, the "European guidelines" concluded that <u>fusion surgery for nonspecific chronic low back pain cannot be recommended unless two years of all other recommended conservative treatment – including multidisciplinary approaches with combined programs of cognitive intervention and exercises – have failed, or such combined programs are not available, and only then in carefully selected patient's with maximum two level DDD.</u>*

<u>ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.</u>

MEDICAL MATERIAL REVIEWED AND LISTED NUMERICALLY:

1. PATIENT CLINICAL HISTORY SUMMARY WITH REASONS FOR DENIAL OF A 360 DEGREE FUSION AT L4-5 AND L5-S1.
2. OPEN LUMBAR MRI REPORT 8/15/07 BY M.D.
3. 9/25/07 ORTHOPEDIC CONSULTATION REPORT BY D.O.
4. 10/30 NEW PATIENT REPORT BY M.D. AND ALSO REPORTS BY THE SAME DOCTOR ON 1/8/08 AND 1/28/08
5. PSYCHOLOGICAL EVALUATION REPORT 12/5/07 BY PHD

6. LUMBAR DISCOGRAM REPORT 12/26/07
7. 2/1/08 REPORT

THIS CASE INVOLVES A MALE WHO WAS REPAIRING DOORS IN LABORATORIES AND SLIPPED AND FELL. HE DEVELOPED BACK PAIN WHICH SOON EXTENDED INTO THE RIGHT LOWER EXTREMITY. HIS HISTORY INCLUDED A PREVIOUS SUCH EPISODE OF BACK PAIN THAT CLEARED TO THE POINT THAT IT WAS NOT GIVING HIM DIFFICULTY AT THE TIME OF THE ACCIDENT. SIGNIFICANT IN HIS HISTORY IS A WEIGHT LOSS OF 160 POUNDS DOWN TO 240 POUND SECONDARY TO LAP BANDING. A LUMBAR MRI ON 8/15/07 SHOWED A SMALL LEFT SIDED L4-5 DISC HERNIATION AND A SIGNIFICANTLY LARGER DISC HERNIATION AT L5-S1 ON THE RIGHT SIDE. PAIN HAS CONTINUED DISPITE MEDICATIONS, PHYSICAL THERAPY AND INJECTIONS. HE HAS BEEN ABLE TO CONTINUED WORK AS OF 1/8/08, BUT CONTINUES TO HAVE DISCOMFORT. MORE EVALUATION WAS CARRIED OUT BY WAY OF LUMBAR DISCOGRAPHY ON 12/26/07 AND THIS SHOWED DIFFICULTIES BOTH FILMS THAT WERE OBTAINED AND PAIN RESPONSE AT BOTH THE L4-5 AND L5-S1 LEVELS. DISC REPLACEMENT AT THE L4-5 LEVEL WITH FUSION AT THE L5-S1 LEVEL WAS RECOMMENDED BUT THIS WAS REFUSED BY THE COMPENSATION CARRIER AND AS A SUBSTITUTE A 360 DEGREE FUSION AT BOTH L4-5 AND L5-S1 WAS RECOMMENDED.

I AGREE WITH THE DENIAL FOR THE PROPOSED OPERATIVE PROCEDURE ON ANTERIOR AND POSTERIOR FUSION AT THE L4-5 AND L5-S1 LEVELS. IT IS NOTED BY THE SURGEON THAT THE PATIENT'S FLEXION AND EXTENTION FILMS FAILED TO REVEAL ANY EVIDENCE OF INSTABILITY FOR WHICH THE PROPOSED OPERATIVE PROCEDURE MAY BE HELPFUL. THERE HAS BEEN PERSISTANT RIGHT LOWER EXTREMITY PAIN ALONG WITH HIS BACK PAIN AND THERE IS AN EXPLANATION ON THE MR WHICH DIAGNOSED AN L5-S1 DISC HERNIATION WITH PROBABLE RIGHT SIDED NERVE ROOT COMPRESSION AND ALSO MENTIONED BY DR. WAS THE POSSIBILITY OF A SIMPLE OPERATIVE PROCEDURE CONSISTING OF DISCECTOMY AT THE L5-S1 LEVEL MAYBE OF BENEFIT AND I THINK PURSUING THAT PROCEDURE WOULD BE MUCH MORE REASONBLE THAN PURSUING THE MAJOR PROCEDURE THAT IS PROPOSED WHICH CAN BE ASSOCIATED WITH MUCH MORE IN THE WAY OF COMPLICATIONS. THE LESS INVASIVE PROCEDURE CONSISTING OF DISCECTOMY WITH DECOMPRESSION OF THE NERVE ELEMENTS IN THE ARE IS NOT ONLY FREQUENTLY ASSOCIATED WITH RELIEF OF LEG PAIN BUT BACK PAIN IS NOT INFREQUENTLY HELPED ALSO. OF COURSE THE MORE EXTENSIVE OPERATION MAY BE NECESSARY IN THE FUTURE BUT AT THE PRESENT TIME I DO NOT THINK IT IS INDICATED.

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

"Guidelines developed by the reviewer over 38 years of evaluating spinal surgical problems."

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