

ReviewTex
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Notice of Independent Review Decision

DATE OF REVIEW: 05/01/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5 TLIF

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

Board Certified Neurosurgeon

REVIEW OUTCOME:

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. History and physical (undated)
2. X-rays lumbar spine 03/02/12
3. MRI lumbar spine 07/26/11
4. Utilization review 03/14/12
5. Reconsideration utilization review 04/05/12
6. IRO referral forms

PATIENT CLINICAL HISTORY [SUMMARY]:

The Injured employee is a male whose date of injury is xx/xx/xx. Records indicate the employee was injured secondary to fall on elevator while he was inside it. He was standing during incident and also upon immediate deceleration of elevator. He had sudden onset of low back pain and leg pain which has progressively worsened. MRI of lumbar spine dated 07/26/11 reported mild levoscoliosis of lumbar spine. There was multilevel degenerative disc changes and lumbar spondylosis with varying degrees of foraminal stenosis. There is also moderate spinal canal stenosis at L4-5. X-rays of lumbar spine on 03/02/12 reported a few mm of anterolisthesis of L4 on L5 in neutral position which is unchanged with flexion and extension. There are no other levels of subluxation.

A request for authorization of L4-5 TLIF was reviewed on 03/14/12 and recommended as not medically necessary. It was noted the employee was injured when the elevator he was in fell 1 ½ floors and came to sudden stop. He had sudden onset of right knee and low back pain. He complains of low back pain and leg pain. MRI of 07/26/12 reported mild levoscoliosis with multilevel degenerative disc changes and lumbar spondylosis with varying degrees of foraminal stenosis. There is also moderate spinal canal stenosis at L4-5. X-rays of lumbar spine on 03/02/12 reported a few mm of anterolisthesis of L4 on L5 in neutral position which is unchanged with flexion and extension and no other levels of subluxation. Physical examination reported light touch decreased left S1. Motor strength was 5/5 throughout bilateral upper and lower extremities. Deep tendon reflexes were 2/4 throughout. There was no clonus. It was determined medical necessity was not established for proposed surgical procedure. The employee sustained an injury due to fall, and complains of low back pain and leg pain. MRI revealed multilevel degenerative disc changes and lumbar spondylosis with varying degrees of foraminal stenosis as well as moderate spinal canal stenosis at L4-5. There was no evidence of motion segment instability on flexion / extension films. There was no comprehensive history of conservative treatment completed to date. Also there was no presurgical psychological evaluation addressing confounding issues were documented. As such, surgical intervention is not recommended as medically necessary.

A reconsideration request for L4-5 TLIF was reviewed on 04/05/12 and request was determined as not medically necessary. It was recommended there was documentation of previous adverse determination due to lack of motion on flexion / extension films, no comprehensive history of conservative treatment, and no presurgical psychological evaluation. It was noted the injured employee has low back pain with nonspecific radiation to leg; decreased sensation in left S1 dermatome; and imaging studies of mild anterolisthesis of L4 on L5, diffuse annular bulge and moderate spinal canal stenosis with crowding of cauda equina nerve roots. However, there is no instability on flexion / extension films or clear rationale for fusion. Therefore, the request is still non-certified. It was noted there was phone conversation with Dr. who stated flexion/extension dynamic views were consistent with at least 1.3 mm of dynamic motion at L4-5; however, he recognized 03/02/12 radiology report did not corroborate these findings. There

was discussion of option of providing addendum radiology report that would substantiate segmental instability at L4-5, but no additional medical reports were received.

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

Based on the clinical information provided, the request for L4-5 TLIF is not supported as medically necessary. The employee is noted to have sustained an injury when the elevator he was in fell 1 ½ floors and came to sudden stop. The injured employee experienced onset of right knee pain and low back pain. The injured employee complained of axial low back pain that radiates into legs. Physical examination reported decreased sensation to light touch on left in S1 distribution. Motor strength was 5/5 throughout bilateral upper and lower extremities. Deep tendon reflexes were 2/4 throughout. MRI of lumbar spine revealed multilevel degenerative disc changes and lumbar spondylosis with varying degrees of foraminal stenosis, as well as moderate spinal canal stenosis at L4-5. Radiographs of lumbar spine including flexion / extension views on 03/02/12, revealed a few mm of anterolisthesis of L4 on L5, which was unchanged with flexion and extension. As noted on previous reviews, there is no comprehensive history of conservative treatment completed to date including physical therapy, activity modification, epidural steroid injections, or other conservative treatment. There also is no presurgical psychological evaluation documented. Given the current clinical data, medical necessity is not established for proposed L4-5 TLIF, and previous denials are upheld on IRO.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Reference:

ODG Low Back Chapter

Patient Selection Criteria for Lumbar Spinal Fusion:

For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative

spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. ([Andersson, 2000](#)) ([Luers, 2007](#))] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. ([Andersson, 2000](#)) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See [ODG Indications for Surgery -- Discectomy](#).)

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see [discography criteria](#)) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) [Psychosocial screen](#) with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. ([Colorado, 2001](#)) ([BlueCross BlueShield, 2002](#))

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).