

Independent Reviewers of Texas
4100 West Eldorado Pkwy #100-373
McKinney TX 75070
independentreviewersoftexas@hotmail.com
Phone: 469-218-1010
Fax#: 469-374-5862

Notice of Independent Review Decision

Date notice sent to all parties]:

04/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

removal of TSRH hardware at L5-S1; transforaminal lumbar interbody fusion (TLIF) with peek at L4-5, pedicle screws L4-5 and lateral mass fusion with a three (3) day inpatient length of stay (LOS)

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Drug screen reports 05/17/12-09/10/12
Laboratory report 05/22/12 and 06/18/12
Manual range of motion testing 02/09/12 and 02/11/13
Operative report date not available due to poor copy quality
Operative report 09/18/97
Clinical record unsigned 07/27/11
MRI lumbar spine 08/22/11

Clinical records 08/10/11-01/09/13
Psychology report 09/06/11
Electrodiagnostic studies 11/09/11
Clinical evaluation 02/09/12
Clinical notes 04/10/12-01/11/13
Procedure note 04/10/12
Emergency room reports 05/09/12
Radiographs lumbar spine 05/09/12
Emergency room reports 07/08/12
Chest x-rays 09/10/12
Clinical record 01/07/13
Prior reviews 01/23/13-02/22/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was followed for a long history of chronic low back pain following multiple lumbar surgical procedures including L4-5 discectomy with interbody fusion and posterolateral fusion from L4 to S1. That appeared to have been performed in 1997. MRI of the lumbar spine in 08/11 showed metallic artifact at L4-5 consistent with an interbody fusion. No fusion change at L5-S1 was apparent. There was adjacent segment disc disease at L3-4 with a possible prior laminectomy at this level. There was moderate to severe compromise of the neural foramina bilaterally. There appeared to be some differences between the radiologist description of the lumbar spine and the descriptions indicating that the patient had a fusion at L5-S1. It appeared that was referring to the L3 and to the L4-5 level. The patient was psychologically cleared for surgery in 09/11. clarified that he felt that the L5-S1 level was a rudimentary disc level. Therefore, L3-4 and L4-5 could be used interchangeably. Electrodiagnostic studies on 11/09/11 revealed a chronic L3-4 radiculopathy. The patient was managed with medications for chronic pain. The patient was seen on 02/09/12, reporting continuing weakness in the left lower extremity with radiating pain. Physical examination at this visit revealed limited range of motion of the lumbar spine. Straight leg raise was reported bilaterally in the supine position. There was mild weakness of the hip flexors and very mild weakness in the quadriceps bilaterally. No sensory loss or reflex changes were identified. The patient was recommended for further epidural steroid injections. The patient underwent epidural steroid injection at L3-4 on 04/10/12. A second epidural steroid injection at L3-4 was performed on 04/10/12. There was no documented long term response from the epidural steroid injections. There was a noted recommendation for discography in 05/12. Further pain management notes noted that the patient had one day of response to epidural steroid injections. There were two separate emergency room visits in 2012 due to uncontrolled low back and lower extremity pain. The patient was recommended to attempt a trial of Lyrica and trigger point injections in 08/12. An addendum dated 08/21/12 indicated that radiographs showed at least 2mm of instability at L3-4. recommended removal of hardware with a lateral mass fusion at L3-4. There was a noted complication with the recommended surgery as

the patient was found to have hepatitis C. The patient still wished to undergo the requested and recommended surgery at L3-4. The letter on 01/07/13 stated that the patient was recommended for a GI specialist or hepatologist work up for the diagnosis of hepatitis C. The patient was recommended to have a platelet transfusion and surgery was performed. Follow up on 01/09/13 had no in depth physical examination. The patient was again recommended for surgery. Interventional pain specialist evaluation on 01/11/13 stated that the patient continued to have chronic low back pain and lower extremity pain. Physical examination revealed loss of range of motion and tenderness to palpation in the lumbar spine. There was continuing mild weakness in the lower extremities on left hip flexion. The patient continued to be managed on oxycontin for pain. The requested revision and removal of hardware with interbody fusion and posterolateral fusion at L4-5 was denied by utilization review on 01/23/13 as there was no discussion on why the patient did not have surgery when it was originally approved in 2012. No updated physical examination or imaging studies were provided for review. The request was again denied by utilization review on 01/30/13 as there was no updated physical examination or diagnostic imaging studies of the lumbar spine. The request was again denied for a third time on 02/22/13 as there was an unclear picture regarding the request as the request was at L4-5.

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

The patient has had a long history of chronic low back pain as well as an L3-4 radiculopathy that was recently established in 2011. MRI of the lumbar spine also revealed significant disc space collapse and motion segment instability at the level above the previous fusion which, per the MRI study, is the L4-5 level. Clinical documentation has established that considers the L4-5 level L5-S1 due to a rudimentary disc at the actual anatomic L5-S1 level. Therefore, this reviewer understands that the request is actually for the L3-4 disc interspace. Although no recent imaging was provided for review, it is highly unlikely that any significant changes have occurred at the L4-5 and L3-4 disc space to warrant additional imaging to again confirm the extent of disc space collapse already noted on prior imaging studies. Furthermore also reported that there were 2mm of motion at the L3-4 level which is further consistent with severe adjacent level segment disc disease. The patient has completed a reasonable course of conservative treatment including multiple epidural steroid injections and long term use of narcotic medications which have been minimal at and which have provided minimal therapeutic value to date. Additionally, it is also noted that the patient was recent and previously recommended for this surgery, however. Complication regarding hepatitis C arose and the surgery was not performed. The hepatitis C condition has been addressed through oncology evaluations and the on call treating oncologist recommended that if surgery were to be performed, pre-operative loading of platelets was reasonable. Given the established L3-4 radiculopathy secondary to severe canal and neural foraminal stenosis as the result of adjacent level segment disc disease at the L3-4 level as the level

numbering has been fully explained and as the patient has been cleared for surgery previously both psychologically and through oncology visits, the recommended removal of hardware at the previously fused level with extension of hardware to the adjacent level which per the MRI study reads as L3-4 followed by interbody fusion and lateral mass fusion would be reasonable and appropriate. Additionally, the patient would reasonably require three day length of stay due to the extensive procedures to ensure no post-operative complications or neurological compromise occur. It is the opinion of this reviewer that the clinical documentation provided for review supports medical necessity for the requested surgical procedures.

IRO REVIEWER REPORT TEMPLATE -WC

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

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines, Online Version, 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)