Claims Eval

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Notice of Independent Review Decision

IRO REVIEWER REPORT - WC

December 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Anterior lumbar interbody fusion @ L3-4, L4-5; Posterior lumbar decompression w/ posterolateral fusion; Pedicle screw fixation @L3-4, L4-5; Inpatient stay: 2 days.

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

American Board of Orthopaedic Surgery

REVIEW OUTCOME:

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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:

- Hospital – ER visit
- 3-1-11 XXXX, MD, office visit
- Physical therapy on 3-1-11, 3-2-11, 3-4-11, 3-7-11, 3-9-11, 3-11-11, 3-22-11, 3-24-11, 3-25-11, and 3-30-11
- Follow up with XXXX, MD, on 3-7-11
- Follow up with XXXX, MD, on 3-14-11
- Follow up with XXXX, MD, on 3-22-11
- Follow up with XXXX, MD, on 3-30-11
- 4-11-11 XXXX, MD, MRI of the lumbar spine

- Follow up with XXXX, MD, on 4-13-11
- Follow up with XXXX, MD, on 4-27-11
- 4-29-11 XXXX, MD, EMG/NCV
- Follow up with XXXX, MD, on 5-6-11
- Follow up with XXXX, MD, on 5-20-11
- Manual muscle testing and range of motion testing on 5-24-11
- 5-24-11 XXXX, MD, office visit
- Follow up with XXXX, MD, on 6-3-11
- 6-10-11 XXXX, MD, operative procedure
- Follow up with XXXX, MD, on 6-24-11
- Manual muscle testing and range of motion testing on 6-28-11
- Follow up with XXXX, MD, on 6-28-11
- Follow up with XXXX, MD, on 7-11-11
- Physical therapy on 7-11-11 and 7-18-11
- 8-3-11 XXXX, MD, office visit
- 8-15-11 XXXX, LPC, behavioral medicine consultation
- Follow up with, MD, on 9-1-11
- Rehab evaluation on 9-12-11
- Follow up with XXXX, MD, on 9-14-11
- 9-15-11 Functional Capacity Evaluation
- 9-19-11 XXXX, MD, office visit
- Follow up with XXXX, MD, on 9-28-11
- Individual psychotherapy on 10-3-11, 10-13-11, 10-18-11, 10-24-11, 11-7-11, and 11-14-11
- Follow up with XXXX, MD, on 10-26-11
- 11-22-11 XXXX, LPC, behavioral medicine re-evaluation
- Follow up with XXXX, MD, on 11-23-11
- 12-14-11 XXXX, MD, office visit
- Follow up with XXXX, MD, on 12-20-11
- 12-20-11 XXXX, MD, operative procedure
- Physical therapy evaluation on 12-21-11
- Physical therapy on 12-21-11
- Follow up with XXXX, MD, on 12-28-11
- Individual psychotherapy on 1-13-12, 1-17-12, 1-26-12, and 2-6-12
- Follow up with XXXX, MD, on 1-17-12
- 1-17-12 XXXX, DC, medical evaluation
- Physical therapy evaluation on 2-4-12
- Follow up with XXXX, MD, on 2-6-12

- 2-18-12 XXXX, MD, office visit
- Physical therapy evaluation on 2-23-12
- Physical therapy on 2-27-12, 3-2-12, 3-5-12, 3-7-12, 3-8-12, 3-12-12, 3-14-12, 3-15-12, 3-19-12, 3-21-12, 3-23-12, 3-26-12, 3-27-12, 3-28-12, 3-29-12, 4-3-12, 4-4-12, 4-5-12, 4-10-12, and 4-12-12
- 3-6-12 XXXX, DO, office visit
- Follow up with XXXX, DO, on 3-26-12
- Follow up with XXXXX, MD, on 4-16-12
- Follow up with XXXX, DO, on 4-23-12
- Follow up with XXXX, DO, on 5-21-12
- UDT 5-21-12
- Follow up with XXXX, MD, on 6-11-12
- Follow up with XXXX, DO, on 7-3-12
- UDT 7-10-12
- 7-10-12 XXXX, MD, x-rays of the lumbar spine
- 7-10-12 XXXX, MD, MRI of the lumbar spine
- Follow up with XXXX, DO, on 8-2-12
- UDT 8-2-12
- Follow up with XXXX, MD, on 8-13-12
- 8-23-12 XXXX, MD, medical evaluation
- Follow up with XXXX, DO, on 8-31-12
- UDT 8-31-12
- Psychological evaluation on 9-13-12
- Follow up with XXXX, DO, on 10-1-12
- UDT 10-1-12
- Follow up with XXXX, DO, on 10-30-12
- 11-7-12 UR non certification.
- 11-21-12 UR non certification.

PATIENT CLINICAL HISTORY [SUMMARY]:

the claimant reports she was hit in the low back with a metal cart. Pain is now radiating down left lower extremity. She rates her pain an 8/10. Impression: Low back pain – acute. Plan: Naproxen and Tramadol.

3-1-11 XXXX, MD, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression: Contusion/strain; lumbar spine. Plan: Light duty. Ibuprofen. Physical medicine times a week for 2 weeks. DWC-73 shows the claimant was returned to work with restrictions on 3-1-11 through 3-18-11.

Physical therapy on 3-1-11, 3-2-11, 3-4-11, 3-7-11, 3-9-11, 3-11-11, 3-22-11, 3-24-11, 3-25-11, and 3-30-11.

Follow up with XXXX, MD, on 3-7-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Physical medicine. Light duty. Acetaminophen and Ibuprofen. DWC-73 shows the claimant was returned to work with restrictions on 3-7-11 through 3-14-11.

Follow up with XXXX, MD, on 3-14-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Physical medicine. Light duty. Ibuprofen. DWC-73 shows the claimant was returned to work with restrictions on 3-14-11 through 3-21-11.

Follow up with XXXX, MD, on 3-22-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Physical medicine. Light duty. Acetaminophen and Ibuprofen. DWC-73 shows the claimant was returned to work with restrictions on 3-22-11 through 3-31-11.

Follow up with XXXX, MD, on 3-30-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Physical medicine. Light duty. Acetaminophen and Ibuprofen. DWC-73 shows the claimant was returned to work with restrictions on 3-30-11 through 4-13-11.

4-11-11 MRI of the lumbar spine interpreted by XXXX, MD, showed L1-2 and L5-S1 are normal. L2-3 broad 2 mm disc protrusion with borderline canal stenosis. L3-4 broad 1 mm disc protrusion with a 3 mm left posterolateral component and mild left neural foraminal narrowing. L4-5 Broad 2-3 mm disc protrusion with mild bilateral neural foraminal narrowing.

Follow up with XXXX, MD, on 4-13-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Physical medicine. Light duty. Acetaminophen and Ibuprofen. Refer to Neurosurgeon for ESI. DWC-73 shows the claimant was returned to work with restrictions on 4-13-11 through 4-27-11.

Follow up with XXXX, MD, on 4-27-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Light duty. Acetaminophen and Ibuprofen. EMG on 4-29-11. DWC-73 shows the claimant was returned to work with restrictions on 4-27-11 through 5-6-11.

4-29-11 EMG/NCV interpreted by XXXX, MD, showed right sided tibial axonal mononeuropathy based on NCS. A severe right sided S1 radiculopathy may also present in a similar manner. Bilateral S1 radiculopathy. Right sided L4 radiculopathy. The active denervation potentials seen on examination of the left vastus medialis may also suggest an L2, L3, and L4 radiculopathy. The active denervation changes

seen on examination of the right anterior and posterior tibialis muscles are also suggestive of involvement of the L5 nerve roots.

Follow up with XXXX, MD, on 5-6-11, the claimant complains of left hip and left lower back pain. Hand written illegible notes. Impression is unchanged. Plan: Light duty. Acetaminophen and Ibuprofen. Refer for ESI. DWC-73 shows the claimant was returned to work with restrictions on 5-6-11 through 5-20-11.

Follow up with XXXX, MD, on 5-20-11, the claimant complains of left hip and left lower back pain that he rates a 7-9/10. Hand written illegible notes. Impression is unchanged. Plan: Light duty. DWC-73 shows the claimant was returned to work with restrictions on 5-20-11 through 6-3-11.

Manual muscle testing and range of motion testing on 5-24-11.

5-24-11 XXXX, MD, the claimant low presents with back pain with radiculopathy to lower extremity that she rates a 9/10. She also complains of left hip pain. Exam shows guarding of limb secondary to pain. She has an antalgic gait. Reflexes are diminished bilaterally. Guarding straight leg raise with lumbar spine pain. L4-5 decreased touch, temperature, pressure, pain, dysesthesias, and aberrant sensations. Tenderness at L2-3 and L5-S1 bilaterally. Range of motion is decreased. Tenderness at left hip with crepitation. Popping sound to hip with movement. Impression: Radicular syndrome of lower limbs. Joint pain, pelvis and thigh. Plan: Start Neurontin, Baclofen, and Ultram. Plan: Refer for injection. If worsening, consider surgical intervention.

Follow up with XXXX, MD, on 6-3-11, the claimant complains of left hip and left lower back pain that he rates a 7-9/10. Hand written illegible notes. Impression is unchanged. Plan: Light duty. DWC-73 shows the claimant was returned to work with restrictions.

6-10-11 XXXX, MD, preoperative diagnosis: Left L4, left L5 disc disease. Left L4, left L5 radiculopathy. Neuroforaminal narrowing L4-5. Postoperative diagnosis: Left L4, left L5 disc disease. Left L4, left L5 radiculopathy. Neuroforaminal narrowing L4-5. Procedure: Left L4, left L5 selective transforaminal root block under fluoroscopic beam guidance and conscious sedation with steroid and anesthetic. Left. L4, left L5 transforaminal epidurogram under fluoroscopic beam guidance and conscious sedation, left L4 and left L5 root.

Follow up with XXXX, MD, on 6-24-11, the claimant complains of left hip and left lower back pain that he rates a 6-8/10. Hand written illegible notes. Impression is unchanged. Plan: Light duty. Physical medicine 2 times a week. DWC-73 shows the claimant was returned to work with restrictions on 6-24-11 through 7-8-11.

Manual muscle testing and range of motion testing on 6-28-11.
Follow up with XXXX, MD, on 6-28-11, the claimant rates her pain a 6/10. She has

45-55% improvement with injection. She desires repeat injection. Plan: L3-4, L4-5 facet block.

Follow up with XXXX, MD, on 7-11-11, the claimant complains of left hip and left lower back pain that he rates a 4-6/10. Hand written illegible notes. Impression is unchanged. Plan: Light duty. Physical medicine. DWC-73 shows the claimant was returned to work with restrictions on 7-11-11 through 7-27-11.

Physical therapy on 7-11-11 and 7-18-11.

8-3-11 XXXX, MD, the claimant has low back pain and left leg numbness. Exam shows flexion is 45 degrees and extension 10 degrees. She has a slightly weaker knee reflex on the left. She complains of left low back pain and left leg numbness. Impression: Lumbar sprain. Possible radiculopathy. Symptom of left leg numbness. Plan: Refer to neurosurgical. Start physical therapy. Drug screen. Refill Tramadol, Gabapentin, Daypro, and Baclofen. Refer for psychotherapy. DWC-73 shows the claimant was returned to work with restrictions on 8-3-11 through 4 weeks.

8-15-11 XXXX LPC, the claimant rates her pain a 6/10. She has pain in the left hip and the back lumbar region down into her foot. Exam shows minimal depression and moderate anxiety. Plan: Recommended individual psychotherapy for a minimum of 6 weeks.

Follow up with XXXX MD, on 9-1-11, the claimant follows up. Plan: Start physical therapy. Pending FCE. She may be evaluated for possible work hardening program. Refill Tramadol, Gabapentin, Daypro, and Baclofen. DWC-73 shows the claimant was returned to work with restrictions on 9-1-11 through 9-14-11.

Rehab evaluation on 9-12-11.

Follow up with XXXX, MD, on 9-14-11, the claimant still has low back pain and complains of left leg numbness. Exam shows she ambulates with slight limp that favors the left leg. Back flexion is 45 degrees and extension 5 degrees. Bilateral straight leg raise showed positive on the left. Left knee jerk reflexes weaker than the right. Impression: Lumbar sprain with left radiculopathy. Probable worsening of the left radiculopathy over the last few weeks. Plan: Repeat EMG/NCV. DWC-73 shows the claimant was returned to work with restrictions on 9-14-11 through 9-28-11.

9-15-11 FCE shows the claimant is functioning at a Light to Medium PDL.

9-19-11 XXXX, MD, the claimant describes being struck by a metal roller with acute onset of low back pain with intermittent shooting pain into the left lower extremity along the anterior thigh and calf muscle, and intermittently into the dorsum of the left foot with numbness and tingling. She rates her pain an 8/10. Exam shows lumbar range of motion is decreased in forward flexion secondary to pain. 4/5 strength in the biceps femoris, tibialis anterior and extensor hallucis longus muscle on the left.

Gait is antalgic. Difficulty with heel walking and less difficulty with toe walking. Straight leg raise positive on the left at 45 degrees. Hypoesthetic in the L4 and L5 on the left. Impression: Lumbar radiculopathy. HNP at L3-4 and L4-5. Lumbago. Plan: She would benefit from a lumbar laminectomy, discectomy, foraminotomy and partial facetectomy at L3-4 and L4-5.

Follow up with XXXX, MD, on 9-28-11, the claimant follows up on back pain. Plan: She is getting approval for surgery. Refill Daypro, Tramadol, Neurontin, and Baclofen. Add Celexa. Psychotherapy evaluation and treatment. DWC-73 shows the claimant was returned to work with restrictions on 9-28-11 through 4 weeks.

Individual psychotherapy on 10-3-11, 10-13-11, 10-18-11, 10-24-11, 11-7-11, and 11-14-11.

Follow up with XXXX, MD, on 10-26-11, the claimant complains of pain and discomfort in her back. Plan: Continue light duty. Refill meds. DWC-73 shows the claimant was returned to work with restrictions on 10-26-11 through 11-26-11.

11-22-11 XXXX LPC, the claimant rates her pain 4/10 with meds and an 8/10 without. She has pain in the left hip and the back lumbar region down into her foot. Exam shows moderate depression and severe anxiety. Plan: Individual psychotherapy for a minimum of 4 weeks.

Follow up with XXXX, MD, on 11-23-11, the claimant continues with low back pain. Exam shows an antalgic gait. DTR's are hyper reflexive on the right. Impression is unchanged. Plan: Continue work restrictions. Refill Baclofen and Daypro. DWC-73 shows the claimant was returned to work with restrictions on 11-23-11 through 12-23-11.

12-14-11 XXXX, MD, hand written illegible notes. DWC-73 per Dr. XXXX. X-rays of the chest showed no acute abnormality.

Follow up with XXXX, MD, on 12-20-11, the claimant presents for preoperative evaluation. Impression: Lumbar disc disease. Normal exam for age. Plan: Cleared for surgery.

12-20-11 XXXX, MD, preoperative diagnosis: Lumbar radiculopathy, herniated nucleus pulposus at L3-4 and L4-5. Postoperative diagnosis: Lumbar radiculopathy, herniated nucleus pulposus at L3-4 and L4-5. Procedure: Lumbar microdiskectomy, laminectomy, foraminotomy and partial facetectomy at L3-4 and L4-5 on the left.

Physical therapy evaluation on 12-21-11.

Physical therapy on 12-21-11.

Follow up with XXXX, MD, on 12-28-11, the claimant reports near complete

resolution of her previous symptomatology. She rates her pain a 6/10. Exam shows lumbar range of motion is decreased in forward flexion secondary to pain. Impression: Status post lumbar laminectomy, discectomy, foraminotomy, and partial facetectomy at L3-4 and L4-5.

Individual psychotherapy on 1-13-12, 1-17-12, 1-26-12, and 2-6-12.

Follow up with XXXX, MD, on 1-17-12, the claimant is status post laminectomy and is doing excellent. She has her back brace on. Exam is normal. Impression is unchanged. Plan: Continue no work status. RTC 1 month. DWC-73 shows the claimant was taken off work on 1-17-12 through 2-26-12.

1-17-12 XXXX, DC, performed a Doctor Evaluation. He certified the claimant has not reached Maximum Medical Improvement.

Physical therapy evaluation on 2-4-12.

Follow up with XXXX, MD, on 2-6-12, the claimant continues to relate near complete resolution of her preoperative symptomatology. She rates her pain a 4-5/10. Exam and impression is unchanged. Plan: Initiate a postoperative rehab program.

2-18-12 XXXX, MD, the claimant has lumbar pain and requests a refill on Hydrocodone. Exam shows pain with flexion and extension. Impression: Lumbar disc disease. Plan: Lodine. Recommended chronic pain management. Therapy is pending. DWC-73 shows the claimant was returned to work with restrictions on 2-18-12 through 3-18-12.

Physical therapy evaluation on 2-23-12.

Physical therapy on 2-27-12, 3-2-12, 3-5-12, 3-7-12, 3-8-12, 3-12-12, 3-14-12, 3-15-12, 3-19-12, 3-21-12, 3-23-12, 3-26-12, 3-27-12, 3-28-12, 3-29-12, 4-3-12, 4-4-12, 4-5-12, 4-10-12, and 4-12-12.

3-6-12 XXXX, DO, the claimant complains of low back pain that she rates a 3/10 with meds and 7/10 without. Exam shows mild to moderate pain with extension and rotation of the lumbar spine. Impression: Low back pain status post lumbar surgery. Lumbar radiculopathy. Chronic pain syndrome. Chronic use of high risk medications. Plan: Obtain UDS. Continue Hydrocodone, Neurontin, and Baclofen.

Follow up with XXXX, DO, on 3-26-12, the claimant complains of low back pain that she rates a 4/10 with meds and 8/10 without. Plan: Increase Norco and Baclofen. Adjust Gabapentin to 300 mg.

Follow up with XXXX, MD, on 4-16-12, the claimant continues to relate marked improvement. She rates her pain a 7/10. Exam and impression is unchanged. Plan: Extend rehab six weeks.

Follow up with XXXX, DO, on 4-23-12, the claimant complains of low back pain that she rates a 7/10 without meds and 3/10 with meds. Plan: Continue Norco, Baclofen, and increase Neurontin to 600 mg. Get MRI.

Follow up with XXXX, DO, on 5-21-12, the claimant complains of low back pain that she rates a 7/10 without meds and 3/10 with meds. Plan: Increase Baclofen and Neurontin.

5-21-12 UDS.

Follow up with XXXX, MD, on 6-11-12, the claimant relates aggravation of her preoperative symptomatology secondary to falling because of left leg giving out. She rates her pain a 6/10. Exam shows lumbar range of motion is decreased in forward flexion secondary to muscle spasms. 4/5 strength in quadriceps femoris, extensor hallucis longus and tibialis anterior muscles on the left. Gait is antalgic. Difficulty with heel walking and left difficulty with toe walk. Straight leg raise is positive on the left at 40 degrees. Hypoesthetic region at L4 and L5 on the left. Impression: Status post lumbar microdiskectomy, laminectomy, foraminotomy, and partial facetectomy at L3-4 and L4-5 on the left. Recurrent lumbar radiculopathy, rule out recurrent disc herniation vs. epidural fibrosis. Plan: Lumbar MRI and x-rays.

Follow up with XXXX, DO, on 7-3-12, the claimant complains of low back pain that she rates an 8/10 without meds and 4/10 with meds. Exam shows moderate spasm and tenderness in the lower lumbar area. Flexion is only 30 degrees. Impression is unchanged. Plan: Continue Baclofen, Neurontin, Hydrocodone, and Ibuprofen.

7-10-12 UDS positive for amphetamine and opioids.

7-10-12 X-rays of the lumbar spine interpreted by XXXX, MD, showed mild to moderate lumbar scoliosis. Mild to moderate degenerative changes seen throughout the lumbar spine. No acute findings are identified.

7-10-12 MRI of the lumbar spine with and without contrast interpreted by Fred Walters, MD, showed mild to moderate disc bulging is seen at multiple levels causing neural foraminal narrowing and compression bilaterally at multiple levels. Endplate edema is seen on both sides of the interspace at L3-L4 secondary to degenerative bone bruising.

Follow up with XXXX, DO, on 8-2-12, the claimant complains of low back pain that she rates an 8/10 without meds and 4/10 with meds. Exam and impression is unchanged. Plan: Continue Baclofen, Neurontin, Hydrocodone, and Ibuprofen. Trial of Pamelor.

8-2-12 UDS positive for amphetamine.

Follow up with XXXX, MD, on 8-13-12, the claimant follows up with no significant improvement. She rates her pain a 7/10. Exam is unchanged. Impression: Recurrent lumbar radiculopathy and disc herniation at L3-4 and L4-5. Lumbar mechanical/discogenic pain syndrome at L3-4 and L4-5. Lumbar retrolisthesis at L3-4 and L4-5. Lumbago, status post previous lumbar microdiskectomy, laminectomy, foraminotomy and partial facetectomy at L3-4 and L4-5 on the left. Plan: Recommended anterior lumbar interbody fusion at L3-4 and L4-5. Posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at L3-4.

8-23-12 XXXX, MD, performed a Designated Doctor Evaluation. He certified the claimant has reached Maximum Medical Improvement on 7-10-12 and awarded the claimant 5% Impairment Rating based on DRE II.

Follow up with XXXX, DO, on 8-31-12, the claimant complains of back pain that she rates a 7/10 without meds and 4/10 with meds. Plan: Continue Baclofen, Neurontin, Hydrocodone, and Ibuprofen. Increase Pamelor to 75 mg.

8-31-12 UDT showed 0 opioids also positive for amphetamines.

Psychological evaluation on 9-13-12. Notes the claimant is an appropriate candidate for the proposed surgical procedure.

Follow up with XXXX, DO, on 10-1-12, the claimant complains of low back pain that she rates an 8/10 without meds and 4/10 with meds. UDT was consistent with her medication. However, the amphetamine level was greater than 999,000 and this is felt to be false positive. Plan: Continue Baclofen, Neurontin, Hydrocodone, Ibuprofen, and Pamelor. Follow up in 30 days.

10-1-12 UDT was positive for amphetamines and negative for opioids.

Follow up with XXXX, DO, on 10-30-12, the claimant complains of low back pain that she rates an 8/10 without meds and 4/10 with meds. Exam shows moderate spasm and tenderness in the lower lumbar area. Flexion is only 30 degrees. SLR is positive on the left. Decreased DTRs to the left leg. Give-way weakness of the left leg. Gait is unsteady with prominent left limp. Impression: Low back pain status post lumbar surgery. Lumbar radiculopathy. Chronic pain syndrome. Chronic use of high risk meds. Plan: Continue with medications: Baclofen, Neurontin. The claimant was provided with Medrol Dosepak, and Pamelor. He also provided with a prescription for Xanax.

11-7-12 UR non certification for lumbar interbody fusion at L3-L4 and L4-L5. The evaluator reported that the August and October 2012 notes from pain management doctor contains little to no clinical findings of radiculopathy. UDT are inconsistent serially and remain unexplainable.

11-21-12 UR non certification for L3-L4 and L4-L5 fusion and wide decompression

secondary to lateral recurrent disc herniations. The evaluator reported the claimant passed psychological screening. Unfortunately, the records of her pain management physicians document 4 episodes of aberrant UDS in the past 8 months. Dr. XXXX was unaware of these results. The claimant was positive for amphetamines on two occasions and negative for prescribed narcotics on two occasions. The evaluator reported that therefore, the claimant was not an acceptable surgical candidate.

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

Based on the records provided, this claimant is status post microdiskectomy, laminectomy, foraminotomy, and partial facetectomy at L3-4 and L4-5 on the left. The claimant reports ongoing low back pain with radicular complaints to the lower extremities. A repeat MRI dated 7-10-12 showed mild to moderate disc bulging is seen at multiple levels causing neural foraminal narrowing and compression bilaterally at multiple levels. This claimant has continued treatment under a pain management physician with the use of medications. The current request is for L3-L4 and L4-L5 fusion. X-rays of the lumbar spine showed mild to moderate lumbar scoliosis. Mild to moderate degenerative changes are seen throughout the lumbar spine. No acute findings are identified. Based on the records provided, this claimant is not a good surgical candidate. Documentation also reflects failure time after time of her urinary drug screens. She has tested positive for amphetamines and has tested negative for opioids, which are currently being provided. The claimant does not have severe structural instability per diagnostic testing and she does not have progressive neurologic dysfunction.

Therefore, the requested anterior lumbar interbody fusion at L3-4, L4-5; Posterior lumbar decompression w/ posterolateral fusion; Pedicle screw fixation at L3-4, L4-5; Inpatient stay: 2 days is not reasonable or medically necessary.

Per ODG 2012 lumbar fusion: Not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. For workers' comp populations, see also the heading, "Lumbar fusion in workers' comp patients." After screening for psychosocial variables, outcomes are improved and fusion may be recommended for degenerative disc disease with spinal segment collapse with or without neurologic compromise after 6 months of compliance with recommended conservative therapy. [For spinal instability criteria, see AMA Guides (Andersson, 2000)] For complete references, see separate document with all studies focusing on

Fusion (spinal). There is limited scientific evidence about the long-term effectiveness of fusion for degenerative disc disease compared with natural history, placebo, or conservative treatment. Studies conducted in order to compare different surgical techniques have shown success for fusion in carefully selected patients. (Gibson-Cochrane, 2000) (Savolainen, 1998) (Wetzel, 2001) (Molinari, 2001) (Bigos, 1999) (Washington, 1995) (DeBarard-Spine, 2001) (Fritzell-Spine, 2001) (Fritzell-Spine, 2002) (Deyo-NEJM, 2004) (Gibson-Cochrane/Spine, 2005) (Soegaard, 2005) (Glassman, 2006) (Atlas, 2006) According to the recently released AANS/NASS Guidelines, lumbar fusion is recommended as a treatment for carefully selected patients with disabling low back pain due to one- or two-level degenerative disc disease after failure of an appropriate period of conservative care. This recommendation was based on one study that contained numerous flaws, including a lack of standardization of conservative care in the control group. At the time of the 2-year follow up it appeared that pain had significantly increased in the surgical group from year 1 to 2. Follow-up post study is still pending publication. In addition, there remains no direction regarding how to define the "carefully selected patient." (Resnick, 2005) (Fritzell, 2004) A recently published well respected international guideline, the "European Guidelines," concluded that fusion surgery for nonspecific chronic LBP cannot be recommended unless 2 years of all other recommended conservative treatments – 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 patients with maximum 2-level degenerative disc disease. (Airaksinen, 2006) For chronic LBP, exercise and cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. (Ivar Brox-Spine, 2003) (Keller-Spine, 2004) (Fairbank-BMJ, 2005) (Brox, 2006) In acute spinal cord injury (SCI), if the spine is unstable following injury, surgical fusion and bracing may be necessary. (Bagnall-Cochrane, 2004) (Siebenga, 2006) A study on improving quality through identifying inappropriate care found that use of guideline-based Utilization Review (UR) protocols resulted in a denial rate for lumbar fusion 59 times as high as denial rates using non-guideline based UR. (Wickizer, 2004) The profit motive and market medicine have had a significant impact on clinical practice and research in the field of spine surgery. (Weiner-Spine, 2004) (Shah-Spine, 2005) (Abelson, 2006) Data on geographic variations in medical procedure rates suggest that there is significant variability in spine fusion rates, which may be interpreted to suggest a poor professional consensus on the appropriate indications for performing spinal fusion. (Deyo-Spine, 2005) (Weinstein, 2006) Outcomes from complicated surgical fusion techniques (with internal fixation) may be no better than the traditional posterolateral fusion. (van Tulder, 2006) (Maghout-Juratli, 2006) Despite the new technologies, reoperation rates after lumbar fusion have become higher. (Martin, 2007) According

to the recent Medicare Coverage Advisory Committee Technology Assessment, the evidence for lumbar spinal fusion does not conclusively demonstrate short-term or long-term benefits compared with nonsurgical treatment for elderly patients. (CMS, 2006) When lumbar fusion surgery is performed, either with lateral fusion alone or with interbody fusion, unlike cervical fusion, there is no absolute contraindication to patients returning even to contact sports after complete recovery from surgery. Like patients with a thoracic injury, those with a lumbar injury should be pain free, have no disabling neurological deficit, and exhibit evidence of bone fusion on x-ray films before returning. (Burnett, 2006) A recent randomized controlled trial comparing decompression with decompression and instrumented fusion in patients with foraminal stenosis and single-level degenerative disease found that patients universally improved with surgery, and this improvement was maintained at 5 years. However, no obvious additional benefit was noted by combining decompression with an instrumented fusion. (Hallett, 2007) Discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) New research shows that healthcare expenditures for back and neck problems have increased substantially over time, but with little improvement in healthcare outcomes such as functional disability and work limitations. Rates of imaging, injections, opiate use, and spinal surgery have increased substantially over the past decade, but it is unclear what impact, if any, this has had on health outcomes. (Martin, 2008) The efficacy of surgery for nonspecific back pain is uncertain. There may be some patients for whom surgery, fusion specifically, might be helpful, but it is important for doctors to discuss the fact that surgery doesn't tend to lead to huge improvements on average, about a 10- to 20-point improvement in function on a 100-point scale, and a significant proportion of patients still need to take pain medication and don't return to full function. (Chou, 2008) This study showed that fusion for chronic lower back pain was the least successful common orthopaedic surgery. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. For chronic lower back pain, improvements were statistically significant but clinically negligible. Although pain was reduced and function improved slightly, outcomes remained in the moderately affected range, quality of life was not improved and rendered worse, on average. While surgery for spinal stenosis and for disc herniation compare well with archetypical orthopaedic operations, the outcomes of surgery for chronic lower back

pain do not even approach those of other orthopaedic procedures, and the data show that patients with back pain are rendered worse off by surgery. (Hansson, 2008) Recent studies document a 220% increase in lumbar spinal fusion surgery rates, without demonstrated improvements in patient outcomes or disability rates. (Deyo, 2009) In a study of 2,378 Washington State workers' compensation claimants who underwent fusion to assess the frequency, timing, and causes of death, the 3-year cumulative mortality rate post-fusion was 1.93% and analgesic-related deaths were responsible for 21% of all deaths and 31.4% of all potential life lost. (Juratli, 2009) A study to compare the surgical experience, clinical outcomes, and effect on body weight between obese and morbidly obese patients undergoing lumbar spine fusion surgery concluded that clinical outcomes were independent of the BMI of the patient, but the incidence of postoperative complications was significant in 45% of morbidly obese and 44% of obese patients. The authors proposed that morbidly obese patients should undergo bariatric surgery before spine surgery in nonemergent situations. (Vaidya, 2009) For nonradicular low back pain with common degenerative changes, there is fair evidence that fusion is no better than intensive rehabilitation with a cognitive-behavioral emphasis for improvement in pain or function, and less than half of patients experience optimal outcomes (defined as no more than sporadic pain, slight restriction of function, and occasional analgesics) following fusion. (Chou, 2009) Posterolateral bone-grafting fusion is not necessary when a Denis type-B thoracolumbar burst fracture associated with a load-sharing score of <or=6 is treated with short-segment pedicle screw fixation. (Dai, 2009) Discography (and not merely the fusion) may actually be the cause of adjacent segment disc degeneration. This study suggested that the phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent to the fusion. (Carragee, 2009) Among Medicare recipients, the frequency of complex fusion procedures for spinal stenosis increased 15-fold in just 6 years. The introduction and marketing of new surgical devices and financial incentives may stimulate more invasive surgery. (Deyo-JAMA, 2010) Results of this study suggest that postmenopausal female patients who underwent lumbar spinal instrumentation fusion were susceptible to subsequent vertebral fractures within 2 years after surgery (in 24% of patients). (Toyone, 2010) A four-year follow-up of an RCT of instrumented transpedicular fusion versus cognitive intervention and exercises for disc degeneration with chronic low back pain concluded that this invasive and high-cost procedure does not afford better outcomes compared with the conservative treatment approach to low back pain, and this study should give doctors pause when recommending lumbar fusion surgery without compelling indications, particularly when strong back rehabilitation programs are available. (Brox, 2010) The ECRI health technology assessment concluded that the evidence is insufficient to support

lumbar fusion being more effective (to a clinically meaningful degree) than nonsurgical treatments (intensive exercise and rehabilitation plus cognitive behavioral therapy) in patients with and without prior surgery. (ECRI, 2007) There is a high rate of complications (56.4%) in spinal fusion procedures, especially related to instrumentation. (Campbell, 2011) The draft AHRQ Comparative Effectiveness Research concluded that limited data suggests that fusion leads to greater improvement in back pain relief and function than physical therapy at 2-year followup, but whether the difference is clinically significant is unclear, and serious adverse events occurred in the fusion group but not the noninvasive-intervention group. (Clancy, 2012) Lumbar spinal fusion surgeries use bone grafts, and are sometimes combined with metal devices, to produce a rigid connection between two or more adjacent vertebrae. The therapeutic objective of spinal fusion surgery for patients with low back problems is to prevent any movement in the intervertebral spaces between the fused vertebrae, thereby reducing pain and any neurological deficits. See also Adjacent segment disease/degeneration (fusion) & Iliac crest donor-site pain treatment.

Lumbar fusion in workers' comp patients: 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. Until further research is conducted there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains “under study.” It appears that workers’ compensation populations require particular scrutiny when being considered for fusion for chronic low back pain, as there is evidence of poorer outcomes in subgroups of patients who were receiving compensation or involved in litigation. (Fritzell-Spine, 2001) (Harris-JAMA, 2005) (Maghout-Juratli, 2006) (Atlas, 2006) Despite poorer outcomes in workers’ compensation patients, utilization is much higher in this population than in group health. (Texas, 2001) (NCCI, 2006) Presurgical biopsychosocial variables predict patient outcomes from lumbar fusion, which may help improve patient selection. Workers' compensation status, smoking, depression, and litigation were the most consistent presurgical predictors of poorer patient outcomes. Other predictors of poor results were number of prior low back operations, low household income, and older age. (DeBerard-Spine, 2001) (DeBerard, 2003) (Deyo, 2005) (LaCaille, 2005) (Trief-Spine, 2006) Obesity and litigation in workers' compensation cases predict high costs associated with interbody cage lumbar fusion. (LaCaille, 2007) A recent study of 725 workers' comp patients in Ohio who had lumbar fusion found only 6% were able to go back to work a year later, 27% needed another operation, and over 90% were in enough pain that they were still taking narcotics at follow-up. (Nguyen, 2007) A recent case-control study of lumbar fusion outcomes in

worker's compensation (WC) patients concluded that only 9% of patients receiving WC achieved substantial clinical benefit compared to 33% of those not receiving WC. (Carreon, 2009) This large historical cohort study suggests that lumbar fusion may not be an effective operation in workers' compensation patients with disc degeneration, disc herniation, and/or radiculopathy, and it is associated with significant increase in disability, opiate use, prolonged work loss, and poor RTW status. (Nguyen, 2011) After controlling for covariates known to affect lumbar fusion outcomes, patients on workers' comp have significantly less improvement. (Carreon, 2010) The presidents of AAOS, NASS, AANS, CNS, and SAS issued a joint statement to BlueCross BlueShield recommending patient selection criteria for lumbar fusion in degenerative disc disease. The criteria included at least one year of physical and cognitive therapy, inflammatory endplate changes (i.e., Modic changes), moderate to severe disc space collapse, absence of significant psychological comorbidities (e.g. depression, somatization disorder), and absence of litigation or compensation issues. The criteria of denying fusion if there are compensation issues may apply to workers' compensation patients. (Rutka, 2011) On the other hand, a separate policy statement from the International Society for the Advancement of Spine Surgery disagrees that worker's compensation should be a contraindication for lumbar fusion. (ISASS, 2011) This study demonstrated a significant difference in outcomes after lumbar spinal fusion between workers' comp populations and those on long-term disability insurance. Both populations only achieved marginal improvement, but workers' comp had a clear, negative influence on outcome even when compared to disability patients. (Gum, 2012)

Lumbar fusion for spondylolisthesis: Recommended as an option for spondylolisthesis. Patients with increased instability of the spine after surgical decompression at the level of degenerative spondylolisthesis are candidates for fusion. (Eckman, 2005) This study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) Unilateral instrumentation used for the treatment of degenerative lumbar spondylolisthesis is as effective as bilateral instrumentation. (Fernandez-Fairen, 2007) Patients with degenerative spondylolisthesis and spinal stenosis who undergo standard decompressive laminectomy (with or without fusion) showed substantially greater improvement in pain and function during a period of 2 years than patients treated nonsurgically, according to the recent results from the Spine Patient Outcomes Research Trial (SPORT). (Weinstein-spondylolisthesis, 2007) (Deyo-NEJM, 2007) For degenerative lumbar spondylolisthesis, spinal fusion may lead to a better clinical outcome than decompression alone. No conclusion about the clinical benefit of

instrumenting a spinal fusion can be made, but there is moderate evidence that the use of instrumentation improves the chance of achieving solid fusion. (Martin, 2007) A recent systematic review of randomized trials comparing lumbar fusion surgery to nonsurgical treatment of chronic back pain associated with lumbar disc degeneration, concluded that surgery may be more efficacious than unstructured nonsurgical care but may not be more efficacious than structured cognitive-behavior therapy. Methodological limitations of the randomized trials prevented firm conclusions. (Mirza, 2007) A comparison of surgical and nonoperative outcomes between degenerative spondylolisthesis and spinal stenosis patients from the SPORT trial found that fusion was most appropriate for spondylolisthesis, with or without listhesis, and decompressive laminectomy alone most appropriate for spinal stenosis. (Pearson, 2010) The latest SPORT study concluded that leg pain is associated with better surgical fusion outcomes in spondylolisthesis than low back pain. (Pearson, 2011) Comparative effectiveness evidence from SPORT shows good value for laminectomy and/or bilateral single-level fusion after an imaging-confirmed diagnosis of degenerative spondylolisthesis [as recommended in ODG], compared with nonoperative care over 4 years. (Tosteson, 2011

Lumbar fusion for Scheuermann's kyphosis: Recommended as an option for adult patients with severe deformities (e.g. more than 70 degrees for thoracic kyphosis), neurological symptoms exist, and pain cannot be adequately resolved non-operatively (e.g. physical therapy, back exercises). Good outcomes have been found in a relatively large series of patients undergoing either combined anterior-posterior or posterior only fusion for Scheuermann's kyphosis. (Lonner, 2007)

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).

IRO REVIEWER REPORT - WC

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

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**