

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: September 10, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Trans-sacral Fusion L5-S1 Posterior Fusion & Instrumentation

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

This physician is Board Certified in Orthopedic Surgery with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

03-29-12: AP and Lateral View of the Lumbosacral Spine, 2 Views

04-27-12: MRI Lumbar Spine

05-11-12: Office Visit

05-21-12: EMG/NCS Lower Extremities

06-20-12: Orthopedic Comprehensive Evaluation

07-20-12: Operative Report

08-01-12: Office Visit

08-01-12: Office Visit

09-17-12: Orthopedic Follow up Evaluation

02-20-13: Follow up Evaluation

03-11-13: Follow up Evaluation

04-12-13: LS-spine Series, 4 views or more

04-12-13: MRI: Pelvis and Hip Joints and Lumbosacral Junction without contrast

05-20-13: Follow up Office Visit

06-10-13: UR performed

08-06-13: UR performed

08-07-13: Psychodiagnostic Assessment

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He initially underwent physical therapy.

March 29, 2012, AP and Lateral View of the Lumbosacral Spine, 2 Views, Impression: Possible paraspinal muscular spasm. Exam is otherwise unremarkable for acute pathology.

April 27, 2012, MRI Lumbar Spine, Impression: 1. Possible paraspinal muscular spasm; exam is otherwise unremarkable for potentially acute pathology. 2. Degenerative disk disease with mild broad-based disk bulge and small central subligamentous disk protrusion at the L5-S1 level.

May 11, 2012, the claimant was evaluated for pain rated 9/10 in his back, left buttock, leg and thigh. Current medications: Ibuprofen and Flexeril. On physical examination there was positive straight leg raising test on the left side. Motor testing revealed no motor deficit. Deep tendon reflexes were 2+ patella tendon bilaterally, 1+ Achilles tendon bilaterally. Impression: Status post injury with L5-S1 disc bulge and central disc herniation. Left L5 radiculopathy. Plan: Obtain x-ray lumbar spine. 2. Complete physical therapy. 3. If still pain following physical therapy, commence with L5-S1 ESI.

May 21, 2012, EMG/NCS of the Lower Extremities, Impression: The above electrodiagnostic study reveals evidence of mild S1 radiculopathy on the right and left.

June 20, 2012, the claimant was re-evaluated for continue back and left leg pain. It was reported the claimant was only able to complete 3-4 session of physical therapy as it actually made the pain worse. Plan: Refer him for L5-S1 ESI.

July 20, 2012, Operative Report, Postoperative Diagnosis: Lumbar disc injury and radiculitis. Procedure: Lumbar epidural steroid injection L5-S1.

August 1, 2012, the claimant was evaluated who noted the ESI failed to produce significant relief of symptoms. On physical examination his gait appeared somewhat upright and stiff. Range of motion of the lumbar spine was limited due to back pain. The light touch and pin prick was remarkably positive on the left side for L5-S1 dermatome radiculopathy. Seated straight leg raising produced primarily low back pain at 90 degrees. Plan: To provide one more ESI at L5-S1 to be absolutely certain that he will respond hopefully to the procedure.

February 20, 2013, the claimant was re-evaluated for significant low back pain that limited his activity levels. The claimant reported the pain was worse on the right side. On physical examination there was positive straight leg raising on the right between 30-70 degrees in a seated position. There was clear-cut decreased sensation to light touch and pin prick in the L5-S1 dermatome on the right and

there was marked decreased range of motion of the lumbar spine. Diagnosis: Failed back syndrome, chronic pain, lumbar disc injury radiculitis. Plan: He has failed care and will need more of a chronic pain type management program. No further injections were recommended.

March 11, 2013, the claimant was re-evaluated who reported the claimant did undergo 2 ESI with no improvement. The claimant voiced at the visit that he did not want to be put into a chronic pain program but would like surgical treatment. Plan: Surgical treatment would consist of L5-S1 fusion. Refer out for lateral X-ray of the sacrum and MRI of the pelvis.

April 12, 2013, LS-spine Series, 4 views or more, Impression: No scoliosis or sacroiliitis. Mild or minimal spondylosis. No spondylolysis or listesis. No compression fracture. I see nothing acute or unstable. Hip joints are unremarkable.

April 12, 2013, MRI of the Pelvis and Hip Joints and Lumbosacral Junction without contrast, Impression: Unremarkable MRI of the pelvis, hip joints and lumbosacral junction area. There is mild spondylosis.

May 20, 2013, the claimant was re-evaluated who reviewed his diagnostic studies and opined: 1. He has an average type of sacrum with an average type of curve on his lateral x-ray. 2. MRI scan shows that there is adequate fat between the rectum and the anterior cortex of the sacrum with no abnormal masses, blood vessels, or adhesions. Plan: opined he was a good candidate for transsacral L5-S1 fusion with posterior instrumentation and fusion at L5-S1. He would begin physical therapy at about 2 weeks for four to six weeks.

June 10, 2013, performed a UR. Rationale for Denial: The patient went for consultation for the review of the x-ray and magnetic resonance imaging (MRI) scan of the sacrum and pelvis. The diagnostic studies documented that the patient had an average type of sacrum with an average type of curve on the lateral x-ray. The MRI scan showed that there was adequate fat between the rectum and the anterior cortex of the sacrum with no abnormal masses, blood vessel, or adhesions. There is no psychological clearance as recommended per evidence based guidelines. EMG showed radiculopathy. There was disc protrusion on MRI. There was failure of injection, PT, medication, activity modification.

August 6, 2013, performed a UR. Rationale for Denial: The medical record provided for review did not document evidence of a lesion (1. Neural arch defect, 1. Segmental instability, 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, 4. The need for revision surgery, 5. Infection, Tumor, or Deformity, 6. And after failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy) for any of which ODG would

recommend a lumbar fusion, therefore the lumbar fusion L5-S1 is not medically necessary.

August 7, 2013, the claimant underwent a psychodiagnostic. Diagnosis: AXIS I: Pain disorder associated with both psychological factors and a general medical condition. Insomnia due to a medical condition. AXIS II: No diagnosis. AXIS III: Chronic back pain. AXIS IV: Severe; medical or health related stress, occupational problems and economic problems. AXIS V: Current GAF 69. Recommendations: Due to the limitations of pain relief from prior and current treatments, appears to be an appropriate surgical candidate. Behavioral medical services, including continued rehabilitative cognitive skill training are essential to Mr. short term and long term maintenance.

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

The previous adverse determinations are upheld. After review of the records provided, I find no exam or imaging signs of a Neural Arch Defect or Instability as outlined in the ODG. The claimant has been diagnosed with failed back syndrome and chronic pain. Not all conservative treatment has been exhausted at this time. A fusion would not address the claimant's radicular symptoms and based on the review of records, would not be a candidate for a L5-S1 fusion. The request for Trans-sacral Fusion L5-S1 Posterior Fusion & Instrumentation is not found to be medically necessary.

PER ODG:

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).

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)