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Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

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)

Description of the service or services in dispute:

L5-S1 Mini 360 fusion with 2-day LOS

Patient Clinical History (Summary)

The patient is a male who sustained an injury on xx/xx/xx. The patient has been followed for a history of low back pain radiating to the left lower extremity. The patient is status post left L5-S1 hemilaminotomy, partial facetectomy, and decompression of the left S1 nerve root on 10/02/13.
Postoperatively, the patient did have improvement in his left lower extremity symptoms; however, there were continuing complaints of low back pain. The patient was referred for postoperative physical therapy and was continued on muscle relaxers and Norco for pain. The patient did report some improvements with physical therapy; however, the patient's low back pain was exacerbated with physical activities. Updated MRI studies were recommended in March of 2014. The MRI study dated 03/31/14 noted severe spondylitic disease at L5-S1 with associated disc desiccation and vacuum disc phenomena at L5-S1. Postoperative changes were noted. There was no high grade stenosis present. There was foraminal stenosis noted, right side worse than left which appeared to be stable. There was discogenic bone marrow edema noted with end plate changes. There was a recommendation for provocative discography to evaluate the L3-4 and L4-5 levels. The clinical report on 08/19/14 noted the patient was unable to undergo discography. The patient continued to report severe complaints of low back pain rated between 6 and 7/10 on the VAS. The patient's physical examination was negative for any neurological deficit. Given the patient's progressive low back pain complaints, the recommendation was for a lumbar fusion 360 degree at L5-S1. It was felt that there was minimal degenerative change at L3-4 and L4-5 to support a multi-level fusion. The patient did undergo a psychological evaluation on 09/10/14 which found no contraindications for surgical intervention.

The requested 360 degree minimally invasive lumbar fusion at L5-S1 was denied on 10/02/14 as there was no indication of instability in the lumbar spine with minimal lower extremity symptoms.

The request was again denied on 10/06/14 as there was no evidence of instability, spondylolisthesis, fractures, tumor, or infection that would warrant lumbar fusion.

Analysis and Explanation of the Decision include Clincial Basis, Findings and Conclusions used to support the decision.

The patient has presented with chronic complaints of low back pain following an L5-S1 lumbar hemilaminotomy, decompression, and facetectomy completed in October of 2013. The patient is noted to have had preoperative degenerative disc disease at L5-S1; however, it is clear that this has substantially progressed since the date of surgery. The most recent MRI studies noted severe spondylitic disease at L5-S1 with near complete collapse of the disc space as well as associated vacuum disc phenomena. The patient has failed a reasonable amount of conservative treatment to date to include physical therapy and medication management with limited response. The patient's low back complaints are still severe, between 6 and 8/10 on the VAS. The patient does not have any further neurological findings on physical examination and the request for lumbar surgery at L5-S1 to include a 360 degree lumbar fusion is to address discogenic or degenerative disc disease at L5-S1. Per guidelines, very carefully selected patients can benefit from lumbar fusion procedures when there has been a failure of conservative treatment to address discogenic low back pain or lumbar degenerative disc disease. Given the clear evidence of vertical instability at L5-S1 with collapse of the disc space as well as the failure of conservative treatment, this patient would meet guideline recommendations regarding lumbar fusion for degenerative disc disease and discogenic low back pain. Any preoperative contraindications psychologically have been ruled out. As such, it is this reviewer's opinion that medical necessity has been established for this request and the prior denials are overturned. As the surgical request has been established as medically necessary, the requested 2 day length of stay for this patient would also be consistent with current evidence based guideline recommendations for post-operative inpatient stays and medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)