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Notice of Independent Review Decision

June 26, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Two to three day inpatient stay for L2-3 circumferential fusion with facetectomy on the left at L2-3 for the lumbar spine.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 13 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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx.

Xx/xx/xx: Office Visit. **Examination:** Extremities: Mildly tender left lateral hip. FROM. **Assessment:** Joint pain, other specified sites NEC- 719.48 **Plan:** Start skelaxin tablet, 800 mg, 1 tab(s) orally, 3 times a day, 7 days(s), 21, refills 0. **Follow Up:** 2 months

11/08/2012: Progress and Therapy Notes **Subjective:** Today's pain rating was 8/10.
03/22/2013: MRI Lumbar Spine. **Impression:** 21. L1-2 Normal. 2. L2-3; Broad 2-3 MM disc protrusion with mild thecal sac stenosis and mild bilateral neural

foraminal narrowing. 3. L3-4, L4-5: Broad 2 MM disc protrusion. 4. L5-S1: 2 MM central disc protrusion.

06/06/2013: Office Visit. **History of Present Illness:** The patient is here today complaining of low back pain. Pt rates pain 8/10. The pain occurs constantly and is associated with left leg. The pain is made worse by standing. The patient tried the following non-operative treatments: physical therapy, steroid injections. **Physical Exam:** Spine: Gait-Normal, Spine ROM: Normal. Extremity: Right upper Extremity: Motor Strength (1-5): Deltoid 5, Bicep 5, Brachioradialis 5, Tricep 5, Finger flexors 5, Hand Intrinsics 5, Sensation-normal. Reflexes: Bicep 2+, Brachioradialis 2+, Tricep 2+, Hoffman Neg Lhermitte's: Neg. Left Upper Extremity: Motor strength (1-5): Deltoid 5, Bicep 5, Brachioradialis 5, Tricep 5, Finger Flexors 5, Hand Intrinsics 5, sensation normal, Reflexes: Bicep 2+, Brachioradialis 2+, Tricep 2+, Hoffman Neg, Lhermittes: Neg. The left upper extremity is non-tender to palpation and has normal alignment, ROM and stability. Right Lower Extremity: Motor Strength: Iliopsas 5, Quadriceps 5, Anterior tibialis 5, Extensor Hallicus 5, Gastrocsoleus 5. Sensation normal. Reflexes: Quadracep 2+, Achilles 2+, Clonus Neg, Babinski Neg. SLR: Neg FST: Neg. The right lower extremity is non-tender to palpation and has normal alignment, ROM, and stability. Left Lower Extremity: Motor Strength: Iliopsoas 5, Quadriceps 5, Anterior tibialis 5, Extensor Hallicus 5, Gastrocsoleus 5. Sensation normal, Reflexes: Quadriceps 2+, Achilles 2+, Clonus Neg, Babinski Neg SLR: Neg FST: Neg The left lower extremity is non-tender to palpation and has normal alignment, ROM and stability. **Assessment:** 1. Back strain/strain. 2. L2-3 disc herniation. **Plan:** By exam and by history and on interviewing him, his pain seems to be coming from the right sided myofascial irritation more so than actually the L2-3 disc herniation. I would like to test this theory by doing a trigger point injection on the right at L4-5 and L5-S1. He will return and get this on his next visit. If this goes well, then he will return to therapy, and if he still continues to hurt, we could consider an L2-3 epidural injection.

08/01/2013: Office Visit. **History of Present Illness:** Patient here following up for low back pain. His trigger point injection has been denied by WC. He complains of severe pain in his back when he is walking and steps wrong. The patient is here today complaining of low back pain. He rates his pain 8/10. The pain occurs constantly. The quality of the pain is described as throbbing, aching. **Assessment:** L2-3 herniated nucleus pulposus. **Plan:** Today, I re-examined him and we talked further about the history of his problem. In addition, I performed an injection of 2% licodaine and 1 cc of steroid Depo-Medrol into the trigger point to the right of his lumbar spine. I am not impressed with the pain relief that he has gotten from the anesthetic placed in this area. In addition, today, he is complaining of progressive radicular symptoms that I would attribute more to the L2-3 disc herniation. At this point, I would recommend an epidural injection at L2-3. We also talked about activity modification and the prognosis of his injury. I also reviewed the MRI again today, and he has a desiccated collapsed disc at L2-3 that I believe is becoming more symptomatic and over time has progressed to radiculopathy.

09/09/2013: Initial Evaluation. DABR. **Initial Evaluation:** The patient has completed a course of conservative medical care including medication, physical therapy and home exercise program. He has reached a plateau in clinical improvement. His symptoms are exacerbated with increased activity and when lifting anything greater than 20 pounds. **Current Medications: multi**-vitamin, fish oils, B12 and uses hydrocodone on a p.r.n. basis. **Physical Examination:** There is moderately restricted ROM by 25% in lumbar flexion, extension and lateral bending. This patient walks with an antalgic gait and is unable to the heel or toe walk. He has diminished strength in the iliopsoas and quadriceps musculature in the right leg. The deep tendon reflex is diminished at the right quadriceps. The other deep tendon reflexes are normal and symmetric. The straight leg raising examination is positive on the right and 75% and negative on the left. There is hypoesthesia to light touch and pinprick in the right L3 distribution. **Plan**: He would like to proceed with a lumbar epidural steroid injection. I have given this patient a new prescription for skelaxin 800 mg to be used on a p.r.n. basis every 8 hours for muscle spasm. I have also given him a new prescription for Valium 10 mg to be taken at bedtime. He has been scheduled to have the procedure performed here on September 20, 2013. It is my opinion that this patient meets the guideline criteria for the injection for pain and radiculopathy this is unresolved with other conservative medical measures. The radicular component is confirmed by physical examination and his previous MRI study.

09/20/2013: Office Consultation. **Office Consultation, Lumbar Epidural Steroid Injection#1, Lumbar Epidurogram, Lumbosacral Spine Series, three views, Fluoroscopy, Oral Sedation.** The patient returns to me today for ongoing follow-up medical care and an electively scheduled lumbar epidural steroid injection. He has been asked to see me in one month for a follow up evaluation. I have asked him to return back to his primary care doctor for two additional visits of physical therapy to the lower back following injection.

10/18/2013: Office Consultation. **Office Consultation:** Patient returns to me today for ongoing follow-up medical care after having a first lumbar epidural steroid injection performed at this facility one month ago. He tells me that after this injection he has noted no significant change or any therapeutic benefits regarding his lower back pain or radicular symptoms following this first injection. His pain remains severe in severity ranging up to 8/10. I have asked him to return to begin in the preauthorization process and any additional testing that may be required prior to spinal surgery. I have given him a new prescription for Norco 10 mg to be used on a p.r.n. basis every 8 hours and Terasin cream to apply to the lower back on a p.r.n. basis up to 3-4 times daily.

10/28/2013: Office Visit. **History of Present Illness:** Patient is returning to follow up for injection. Patient said he feels that the injection may have made the pain worse. He wants to figure out what is wrong with him and he is tired of going from. The patient is here today complaining of low back pain. He rates pain an 8/10. The pain occurs intermittently and is made worse by excessive walking. **Assessment:** L2-3 herniated nucleus pulposus. **Plan:** He had an epidural steroid injection and at this point, is still hurting considerably. The injection and the

physical therapy have both failed. He continues to have lower back pain from a collapsed and desiccated L2-3 disc and he is also having left sided radicular symptoms from foraminal stenosis. My recommendation at this point would be an L2-3 circumferential fusion with facetectomy on the left at L2-3. This would enable me to decompress the foramen on the left and address the radicular symptoms. I would perform the interbody fusion from a lateral approach and then also perform a posterior fusion with the left L2-3 facetectomy and instrumentation. We will submit for this procedure.

12/20/2013: UR. **Rational for Denial:** Per peer reviewer: Deny. The ODG state that prior to spinal fusion all pain generators have been identified and treated, all physical medicine and manual therapy interventions have been completed, there are X-rays demonstrating spinal instability, there is imaging demonstrating disc pathology correlated with symptoms and examination findings, spine pathology is limited to two levels, a psychosocial screen has been performed addressing confounding issues, and, if the individual smokes, that the individual refrain from smoking for at least six weeks prior to surgery. The medical documentation provided for review reported the claimant has undergone physical therapy, oral medications, and epidural steroid injection. There were no X-rays of the lumbar spine with a radiologist's interpretation demonstrating any spinal instability. The MRI demonstrated pathology at the L2-L3 level, but there was no documentation of any nerve root impingement. There was no psychosocial screen provided for review addressing confounding issues.

01/14/2014: Pre-surgical behavioral health evaluation **Conclusions:** reports feeling well informed about the upcoming surgical procedures and hopeful that it will permit him to be more active in the future. He does not appear to have overly-optimistic expectations about the results although he appears to be appropriately hopeful about his recovery. He appears comfortable with his doctor. He does believe that he is making the best possible decision and has consulted adequately with professionals. There do not appear to be signs or symptoms to suggest any emotional problems as a consequence of upcoming surgery at this time. Mor. affirmed that all answers were truthful and accurate. does not exhibit psychological or behavioral risk factors shown in the literature that predict a poor spinal surgery outcome. Based on Block's model, he falls in the "good prognosis" category, thus my recommendation for his spinal surgery is clear for surgery, no psych needed.

02/20/2014: Office Visit. **History of Present Illness:** Patient is here to review X-rays lumbar spine with flex/ext to proceed with surgery. He complains of unable to sleep for the last week due to pain. He rates pain as 10/10. The pain occurs constantly. It is associated with right leg pain, left leg pain. Pain is made worse when he gets cooled off. The quality of pain is described as throbbing. **Assessment:** Lumbar radiculopathy. **Plan:** He returns today with his surgery being denied. The denial is based on two factors. One, they report that they did not receive his psychology eval. The eval is in my medical records and he has been cleared for surgery and declared low risk. I will send this over to them. In addition, they denied the surgery based on how the MRI reports read. My review

of the MRI shows that he clearly has significant stenosis and compromise of the neural structures. CT Myelogram would be of benefit for him to further demonstrate this. I will see him back after CT Myelogram of the lumbar spine.

03/19/2014: Lumbar Myelogram. **Impression:** Left paracentral/lateral disc herniation or protrusion at L3/4.

03/19/2014: CT Lumbar spine without contrast. **Impression:** 1. 6 mm left paracentral/lateral disc herniation or protrusion at L2/3 compresses the thecal sac left of midline and contacts nerve roots within thecal sac but the nerve root laterally in the exiting foramina exits without overt or invisible impingement. 2. 5 mm disc at T11/12 appears to be chronic but indents the thecal sac and causes mild canal stenosis. 3. The remaining level of the lumbar spine only shows minimal disc protrusions. There is no identifiable fracture or acute osseous abnormality.

04/11/2014: Office Visit. **History of Present Illness:** Patient returns for results of CT Myelo. He states he is having sharp pain that radiates down to both legs, more the left leg than the right. He states he has numbness in his left foot. He is not able to walk more than 5 minutes because the pain will increase. The patient is here today complaining of low back pain. He rates his pain a 7/10. Pain occurs constantly and is associated with right leg pain, left leg pain, right leg/foot numbness/tingling. The pain is made worse by cold weather, walking, standing. The quality of the pain is described as throbbing, stabbing, throbbing. The patient tried the following non-operative treatments: physical therapy, steroid injections, pain medicine. **Assessment:** Lumbar HNP w Radiculopathy **Plan:** Reviewed and discussed history, diagnostic and exam findings with patient. Reviewed and compared CT Myelo and MRI lumbar. CT Myelo confirms 6mm left paracentral/lateral disc herniation or protrusion at L2/3 compresses the thecal sac left of midline and contacts nerve roots within the thecal sac. This would explain bilateral lower extremity radiculopathy. There is also a 5 mm T11/12 indents thecal sac and causes mild canal stenosis. The conservative measures of medications, injections, physical therapy and activity modification have all failed. He continues to have lower back pain from a collapsed and desiccated L2-3 disc that impinges nerve roots in and he is having increased symptoms. My recommendation is resubmit for L2-3 circumferential fusion with facetectomy on the left at L2-3. This would enable me to decompress the foramen on the left and address the radicular symptoms but cause some instability. I would perform the interbody fusion from a lateral approach and then also perform a posterior fusion with the left L2-3 facetectomy and instrumentation. We will submit for this procedure.

04/29/2014: UR performed. **Rational for Denial:** The claimant is a male with low back pain and bilateral leg pain, refractory to conservative management to date. The most recent office evaluation documented, 4/11/14, states the patient has left greater than right leg pain with some proximal weakness of the lower extremities, Recent CT myelography in March of this year demonstrated multi-level degenerative disc disease and a left L2-3 disc protrusion without significant facet

disease. No instability was documented. The disc protrusion was left paracentral, not foraminal or extra-foraminal. Based on the clinical documentation and Official Disability Guidelines Treatment Guidelines, the requested services are denied. Surgical fusion is not supported based on the clinical documentation/imaging results.

05/20/2014: UR. **Rational for Denial:** The previous denial on 4/28/14 was due to the imaging results. The previous denial is supported. Additional records were not provided for review. The ODG indicate prior to fusion all pain generators should have been identified and treated. Physical medicine and manual interventions should have been completed and X-rays must demonstrate spinal instability. A psychosocial screening should have been performed addressing confounding issues. The records reflect the patient has undergone physical therapy, injections, use of oral medications, and activity modification without improvement. The records do not reflect a psychosocial screening was performed. The imaging did not demonstrate instability at the requested level.

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

The previous adverse determinations are upheld. The patient is not indicated for a L2-3 circumferential fusion with facetectomy. The Official Disability Guidelines (ODG) supports lumbar fusion in the setting of lower back pain caused by segmental instability. The medical record does not indicate any evidence of instability at L2-3 on flexion and extension views of the lumbar spine.The ODG also requires identification of all pain generators prior to spinal fusion. The patient complains of pain in the left and right legs. The MRI and CT both demonstrate disc disease at L2-3, without any evidence of nerve root impingement. The pain generator is not clear in this case. A lower extremity EMG-nerve conduction study would be recommended to confirm the source of radiculopathy before surgery is considered. For these reasons, Two to three day inpatient stay for L2-3 circumferential fusion with facetectomy on the left at L2-3 for the lumbar spine is not medically necessary at this time and should be denied.

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. (SeeODG 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)**