

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: May 28, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L4-5 Mini 360 Fusion with 2-day Length Stay

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

This physician is Board Certified Orthopaedic Surgeon with over 15 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 while working on xx/xx/xx. He was injured while walking; he slipped. He did not fall but jerked his body in an attempt to avoid falling. He had low back pain and left leg pain, denying tingling and numbness. He reported that muscles in the back of his leg were uncomfortable.

07-31-97: Workers' Compensation Report. After the stated injury on xx/xx/xx, radiographs revealed minimal degenerative joint disease and degenerative disk disease of L4-5. The patellar and Achilles reflexes were within normal limits. There was decreased flexion of the lumbar spine and paravertebral muscle spasm and tenderness to palpation. Recommend PT 3x week for 3 weeks. He is to return for re-evaluation in 3 weeks. Recommend DayPro 600mg two q daily with

food or milk, Flexeril 10mg TID PRN spasms, Lortab 7.5mg Q4hr for pain. Would recommend a MRI of low back if he has no improvement in 3 weeks.

09-10-97: MRI of Lumbar Spine w/wo Contrast. Impression: 1. L3-4 normal MRI. 2. L4-5 a combination of chronic disc protrusion, central/left paracentral with ventral thecal sac effacement, and enhancing fibrosis. Status post left laminotomy. 3. L5-S1 negative for disc herniation or compressive disc disease. Bilateral facet arthropathy.

06-21-02: History and Physical Exam. Chief complaint: Shooting pain in his medial lower back which extends to the right where he also feels numbness in his right buttocks, tingling in his right posterior lower extremity and right plantar foot, sometimes experiencing tingling in his left lower back and left plantar foot. Claimant stated about 2-3 weeks after the initial injury; he began noticing low back pain, which progressed. PE: Lumbar Spine: There is moderate tenderness to palpation over the lumbar paras, ROM of the lumbar spine is decreased. Impression: Degenerative disc disease lumbar spine, myofascial pain syndrome lumbar and gluteal.

06-21-02: Evaluation. Claimant received a sacroiliac injection on 07/26/01. On 10/08/01 he had a bilateral sacroiliac joint rhizotomy and medial branch facet rhizotomy that gave him relief for approximately five months. On 11/19/01 he had a right sacroiliac joint rhizotomy. On 3/18/02 he had a medial branch facet rhizotomies and a right sacroiliac joint rhizotomy. He reports that he generally gets about five months of relief each time he has these procedures. He continues to take one to two Lortab per day. He has been diligent with his HEP and reported that he is walking on a treadmill every other day. On PE there is tenderness to palpation in the bilateral lumbar paraspinals. Lumbar ROM is decreased in all planes. The physical examination continues to be consistent with the diagnoses of degenerative disease of the lumbar spine and myofascial pain in the lumbar paraspinals. Further surgical back procedures are not indicated at this time, or further diagnostic testing, however he will continue to require the facet rhizotomies approximately twice a year that may decrease with further HEP.

06-20-13: Office Visit. Chief complaint: bilateral SI pain, severe both SI joints, SI injections give good pain relief, short term. Sitting increase pain, mowing lawn increases pain, no lower back pain. Norco is not lasting 3-4 hours, point tenderness SI joint bilaterally. PE: Musculoskeletal System: Lumbar/Lumbosacral Spine: A Patrick-Fabere test was positive at the right and left sides. Pelvis: both sacroiliac joints showed tenderness on palpation, point tenderness sacroiliac joint bilaterally. Assessment: Sacroilitis bilateral, 720.2; Postlaminectomy syndrome, 722.83, FBS. Plan: Rhizotomy, bilateral sacroiliac joint, Roxycodone 15mg Q4hr PRN pain, discontinue Norco.

08-05-13: Encounter Note. Claimant complained of severe pain in the SI area of the lumbar spine, he cannot walk or sit for long without pain becoming severe he has to try to shift to a position of comfort. After sitting pain goes down the posterior thigh to just above the knee; after sitting for long periods the posterior

thighs become numb. Claimant reported 70% improvement after last procedure for months after procedure but pain has now returned after 14 months. Pain is present 100% of the time with occasional increased intensity, worse on right side but is constant on both, walking and arising exacerbated the pain with numbness of the medial right ankle into the arch. Current medication: Alprazolam 0.25 mg, Roxicodone 15mg, Skelaxin 800mg. PE: Musculoskeletal: Lumbar: lumbosacral spine exhibited tenderness on palpation, tenderness exhibited on palpation of spinous process, sciatic notch on the right and left exhibited tenderness on palpation, lumbosacral spine exhibited spasms of the paraspinal muscles bilaterally, lumbosacral spine flexion, extension, rotation to left and right are abnormal. SLR right and left leg were positive. Pelvis: right and left sacroiliac joint showed tenderness on palpation. Neurological: Sensation: Decreased response to tactile stimulation of the lower L3 aspect of the right thigh, decreased response to tactile stimulation of the sural nerve of the right calf. Assessment: Sacrolitis bilateral, 720.2; Lumbago, intractable pain syndrome, 724.2 IPS; Lumbar spondylosis without myelopathy, 721.3; Lumbar Postlaminectomy syndrome, post laminectomy syndrome lumbar, 722.83. Plan: Bilateral SI Rhizotomy, start Skelaxin 0.5 to 1 QID PRN muscle spasms.

10-05-13: MRI L-Spine w/wo Contrast. Impression: Left laminectomy at L4-5. The L4-5 disk is dehydrated and narrowed, 1.7 mm generalized disk bulging is present. No extended disk fragment present. 2. Right neural foraminal stenosis at L4-5 is present. 3. Slight 1.2 mm disk bulging at L5-S1. 4. Bilateral facet arthropathy at L5-S1. 5. Lumbar spine otherwise negative.

10-05-13: MRI Sacrum/Coccyx w/o Contrast. Impression: 1. 5.3 mm subluxation of the distal coccygeal segment. This is seen on sagittal view only. 2. The sacrum itself is normal. 3. SI joints are normal in appearance without destruction or erosion. 4. No sacral fracture present.

10-21-13: Office Visit. Claimant has undergone at least 15-20 facet rhizotomies in the low back and SI joint, currently taking oxycodone when necessary, yet continues to work. He noted low back pain 8/10 and some leg pain 6/10. He stated activities of daily living are symmetrically affected with him only being able to stand for 30 mins or sit for 30 mins and cannot do sport activities. PE: Reflexes are symmetrically diminished. EHL and TA reveals weakness of the left extensor hallucis SLR is productive of low back pain bilaterally and Faber for slightly in the right lower back. He is tender not only in the midline, but also laterally of the iliac crest, X-Ray: asymmetric collapse at the L4-5 level on the right there is also tilting of the L5-S1. The disc spaces from L3-4 proximal and appeared to be normal. There is no instability with flexion and extension. He does have an enlarged transverse process on the left L5 level it is difficult to determine if there is an articulation there. There is a left sided laminotomy at the L4-5 level. Assessment: Chronic low back pain and since on-the-job injury xxxx, s/p previous lumbar laminectomy, left L4-5, rule out Postlaminectomy syndrome with normal disc above and below as per MRI scan, s/p extensive conservative treatment including multiple injections, as well as rhizotomies in the low back as well as of the SI joint and medications. Postlaminectomy Syndrome, lumbar

722.83, Low back pain 724.2. Orders: office consult – complex, 2. No electric script sent, 3. Discogram: lumbar spine w/CT w/TV protocol levels L4-5 only with 4. L Spine; AP/LAT/FLEX/EXT.

11-05-13: Behavioral Medicine Evaluation. Medical Treatment Recommendations and Client Management Suggestions: Based on this Clinical Health Psychology evaluation he is clear for the discogram with no concern that psychological issues will influence results. Based on this presurgical psychological screening, the claimant is clear for spine surgery with a good psychological prognosis for pain reduction and functional improvement. The claimant needs to be aware that maximal surgical recovery will result for active participation in post-surgical rehabilitation and pain management activities. He will need a great deal of information and structure in order to achieve maximal gains from the surgery. He will need to stay on Sertraline for at least 6 months post-op.

03-13-14: Office Visit. Claimant presented with continued low back pain with decreased sensation in the L5 distribution. Assessment: Chronic low back pain and since on-the-job injury xxxx, status post lumbar laminectomy, left L4-5, with Postlaminectomy syndrome with normal disc above and below as per MRI scan, status post extensive conservative treatment including multiple injections, as well as rhizotomies in the low back as well as the SI joint and medications and rehabilitation over the years since his original back surgery with asymmetric collapse on the right and normal disc above below with instability and slight left lateral listhesis. Plan: He is a candidate for stabilization procedure and a candidate for an anterior posterior fusion. His asymmetric collapse at the L4-5 level that is causing his mild lumbar scoliosis. History of hypertension 401.9, Postlaminectomy syndrome, lumbar 722.83, low back pain, 724.2.

03-25-14: UR. Reason for denial: The claimant had a laminectomy in 1995. He has been treated with medication, PT, ESI, medial branch blocks and rhizotomies. He has continued to have some symptoms. He has back pain and right leg pain. He has been treated for mental problems with stress at work. He has back pain and right leg pain. He has been treated for mental problems with stress at work. He is currently not working and has a continued history treatment for anxiety. He is six feet two inches and 240 lbs and with a normal neurologic exam. MRI on 10/5/13 notes degenerative changes at L4-5 and L5-S1. His most recent visit on 3/13/14 notes a normal neurologic exam except decreased sensation a L5, side not noted. The claimant does not meet the ODG guidelines. He has had continuous back pain for years. There is no localization of the pain clinically. There is no indication of mechanical pain. All pain generators are not located. He has degenerative changes below the level requested. There are no arch or boney defects noted and no flexion/extension views or other evidence of instability. His smoking history says former smoker and we do not know when that stopped. Therefore, the medical necessity of the requested procedure is not established.

05-05-14: UR. Reason for denial: The MRI of the lumbar spine on 09/10/97 reveals that at L4-5, there is a chronic disc protrusion, central/left paracentral with

ventral thecal sac effacement and enhancing fibrosis. At L5-S1, there is bilateral facet arthropathy. The MRI of the lumbar spine on 10/05/13 reveals left laminectomy at L4-5 with 1.7 mm generalized annular disc bulge. There is right neural foraminal stenosis at L4-5. There is a slight 1.2 mm disc bulge at L5-S1 and bilateral facet arthropathy at L5-S1. There is no instability with flexion and extension. The claimant has been treated with multiple lumbar medial branch blocks facet rhizotomies at bilateral L3-S1, sacroiliac joint injections, lumbar epidural steroid injections, PT, medications and lumbar laminectomy. However, the claimant continues to have pain and symptoms in the back with radiation of symptoms in right leg. Examination reveals pain with flexion-extension. There is decreased sensation in the L5 distribution. There is weakness of the extensor hallucis longus and tibialis anterior with positive SLR test. The claimant has been cleared by a psychologist for discogram and lumbar surgery, as this claimant has good psychosocial prognosis for pain reduction and functional improvement. The current request is inpatient L4-5 mini 360 fusion with 2 day length of stay. In this case, it is noted that the claimant has had persistent low back pain with radiation of symptoms in the lower extremities despite prior PT, medications, activity modification, interventional pain management and laminectomy. Although there is indication that the claimant has been cleared by a psychologist to undergo lumbar surgery, the submitted report on 10/21/13 indicates that there is no instability at L4-5 on flexion and extension. Considering the extensive nature of the procedure, absent documentation of such or extenuating circumstances, the claimant does not meet criteria for lumbar fusion. Recommend non-certification.

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

The previous adverse determinations are upheld and agreed upon. The L4-5 Mini 360 Fusion is not indicated in this patient. The Official Disability Guidelines (ODG) requires evidence of segmental instability prior to consideration of a spinal fusion. The 10/21/2013 office visit specifically indicates that there is no instability identified in the flexion and extension views. A spinal fusion is not indicated at L4-5 in the absence of instability. Furthermore, the pain generators have not been fully defined. The patient has documented facet arthropathy at L5-S1. He has also received multiple interventional pain procedures to the sacroiliac joints. It is unclear whether these regions should be addressed at the time of surgery. Therefore, after reviewing the medical records and documentation provided, the request for L4-5 Mini 360 Fusion with 2-day Length Stay is not recommended and denied.

Per ODG:

Fusion (spinal)	<p>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 - Spondylytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability</p>
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	<p>(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.)</p> <p>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)</p> <p>For average hospital LOS after criteria are met, see Hospital length of stay (LOS).</p>
Hospital length of stay (LOS)	<p>ODG hospital length of stay (LOS) guidelines:</p> <p>Discectomy (<i>icd 80.51 - Excision of intervertebral disc</i>) Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges (mean) \$26,219 Best practice target (no complications) -- <i>Outpatient</i></p> <p>Laminectomy (<i>icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root</i>) Actual data -- median 2 days; mean 3.5 days (± 0.1); discharges 100,600; charges (mean) \$34,978 Best practice target (no complications) -- <i>1 day</i> <i>Note: About 6% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, posterior (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>) Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) \$86,900 Best practice target (no complications) -- <i>3 days</i> <i>Note: About 15% of discharges paid by workers' compensation.</i></p> <p>Lumbar Fusion, anterior (<i>icd 81.06 - Lumbar and lumbosacral fusion, anterior technique</i>) Actual data -- median 3 days; mean 4.2 days (± 0.2); discharges 33,521; charges (mean) \$110,156 Best practice target (no complications) -- <i>3 days</i></p> <p>Lumbar Fusion, lateral (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>) Actual data -- median 3 days; mean 3.8 days (± 0.2); discharges 15,125; charges</p>

	<p>(mean) \$89,088</p> <p>Best practice target (no complications) -- 3 days</p> <p>Artificial disc (84.65 - Insertion of total spinal disc prosthesis, lumbosacral)</p> <p>Actual data -- median 3 days; mean 2.6 days (± 0.1); discharges 1,653; charges (mean) \$65,041</p> <p>Best practice target (no complications) -- <i>Never recommended</i></p> <p><i>Note: About 30% of discharges paid by workers' compensation.</i></p> <p>Artificial disc revision (84.68 – Revision/replacement artificial spinal disc prosthesis, lumbar)</p> <p>Actual data -- median 3 days; mean 4.4 days (± 0.8); discharges 169; charges (mean) \$58,355</p> <p>Best practice target (no complications) -- <i>Never recommended</i></p>
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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)**