

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** November 4, 2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

IP APLIF @ L5-S1 2258 22845 22851 20930x2 20936x2 38220x2 22612 22840  
with 5 days LOS.

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his back while lifting and twisting while working on xx/xx/xx.

08/09/13: MRI Lumbar Spine report. IMPRESSION: There is a posterior central disc herniation measuring 10 mm at L5-S1 with subtle left lateralization as described above in greater detail. Mild generalized facet arthropathy.

12/11/13: A letter indicated that the claimant was diagnosed with a 10—mm disc herniation at L5-S1 with lateralization, left greater than right, impinging on the S1 nerve root. It was noted that he had failed PT and had a history of steroid sensitivity. The plan was for laminectomy and discectomy at L5-S1.

01/08/14: The claimant was evaluated who noted that he was given two weeks of PT but became much worse and was told to stop the therapy. He had tried anti-inflammatories that did not help. A note is made that surgery was denied by the claimant's insurance carrier secondary to not having had undergone ESI. On

exam, he had positive SLR and Lasegue's on the left. On the right, he had mildly positive hp pain with SLR. Homan's sign was negative. His pulses were intact. Reflexes at left ankle were 1+/4 and on the right at 2+/4. LESI was recommended.

01/21/14: Operative Report. POSTOPERATIVE DIAGNOSIS: Lumbar radiculopathy. PROCEDURE PERFORMED: Caudal epidural steroid injection, L5-S1.

02/03/14: The claimant was evaluated with reported pain rating of 8/10. It was noted that the claimant described an allergic reaction to the steroid following LESI at L5-S1 performed on 01/21/14. He broke out in a substantial rash with petechiae (it was noted that this supported his claim that he had a history of steroid sensitivity). He felt that his symptoms were worse after the injection. He had progression of his left leg pain as well as worsening of his newly developed right leg pain. He denied loss of bowel or bladder continence or saddle anesthesia. His pain was markedly worsened with coughing, sneezing, and positioning. On exam, he ambulated with a pitched-forward left-sided antalgic gait. Posterior lumbar paraspinal muscles demonstrated moderate spasm. He demonstrated persistent restricted uncomfortable lumbar range of motion on flexion/extension and lateral bending. His left gastrocnemius demonstrated 4/5 strength. Light touch sensation was intact and symmetric from L1-S1. He noted dysesthesia in bilateral lower extremities going down his L5-S1 distribution. Positive SLR on the right. Positive straight contralateral leg raise exam left. Symmetrical patellar reflex. Absent Achilles reflex left. Downgoing toes. No clonus. Negative FABER's, Stinchfield's hip impingement sign. noted that the claimant had failed activity modification, medication therapy including Lodine, Flexeril, and hydrocodone, and PT. He developed a reaction to LESI. Laminectomy and discectomy at L5-S1 were recommended.

02/17/14: Operative report. POSTOPERATIVE DIAGNOSIS: Left lower extremity weakness. Sciatica. Muscle spasm. L5-S1 herniated nucleus pulposus. Lumbar radiculopathy. OPERATION PERFORMED: Laparoscopic hemilaminectomy, medial facetectomy, and foraminotomy and partial discectomy at L5-S1.

03/10/14: The claimant was evaluated postoperatively stating that he initially did well postoperatively but was now worse than prior to surgery. He noted that with any increase in his intra-abdominal pressure such as with passing flatulence, his leg pain would become interoperable. He denied loss of bowel or bladder function. He denied drainage from his wound. On exam, his incision was intact. He had "very positive straight leg raise at 16 degrees." He had 3+/5 gastrosoleus strength on the left. Sensation was intact. Downgoing toes. No clonus. Absent Achilles reflex on the left. Standing AP and lateral x-rays taken on date of visit demonstrated stable alignment. An MRI scan was ordered.

03/10/14: MRI Lumbar Spine report. IMPRESSION: Recent L5-S1 laminectomy. Moderate left lateral recess disc protrusion contributes to moderate left lateral recess stenosis affecting the left S1 nerve root.

03/12/14: The claimant was evaluated to discuss a lumbar fusion. Advised was a revision left hemilaminotomy and partial discectomy.

04/01/14: A discharge summary was submitted noting date of admission of 03/31/14 and discharge date of 04/01/14. The assessment and plan noted s/p revision L5-S1 left lami MIS (no op notes provided).

04/07/14: The claimant was evaluated for a first postoperative follow-up visit from revision left-sided L5-S1 hemilaminectomy, medial facetectomy, and partial discectomy. He felt that his left lower extremity radicular symptoms had improved. He was having substantial low back pain. On exam, his incision was clean, dry, and benign appearance. Standing AP and lateral x-rays of the lumbar spine taken postoperatively demonstrated no listhesis and no scoliosis. He was to return in six weeks.

04/14/14: The claimant returned stating that he felt he had a turn for the worse regarding his back and leg pain. He complained primarily of "tailbone pain" as well as left lower extremity radicular symptoms. On exam, he was able to rise and ambulate about the room. He was antalgic to the left. He did have a straight leg raise to the left. His incision was healing. He was given a Medrol Dosepak and was to return in three days.

04/17/14: The claimant was again evaluated. It was noted that he felt he was improving. His exam noted that he walked about the exam room without weakness or ataxia. He had normal strength in the bilateral lower extremities. He was to return in one week.

04/26/14: The claimant returned. He noted that his radicular symptoms had improved but his back pain had worsened. His exam remained unchanged. He was to return in one week.

05/05/14: The claimant was evaluated. He stated that he felt much worse and was having symptoms in both legs. He complained of severe dysesthesias radiating down his posterior thigh to his toes. He also complained of a new symptom of pain radiating down his lateral thigh across his knee on the left. He described that his tailbone pain had returned. He described falling twice over the course of the previous week. On exam, he sat listing to the right. He moved through the course of the exam in an apparent effort to find comfort. He could rise from a seated position with some difficulty and obvious discomfort. He ambulated with a left-sided antalgic gait. He could not toe walk on the left. Both supine and seated SLR were found to be strongly positive at 20 degrees. 3+/5 gastrosoleus strength on the left. Gross sensation intact. Severe dysesthesias radiating down his posterior thigh to his toes. Symmetrical patellar reflex. Absent left Achilles reflex. Downgoing toes, no clonus. An MRI was ordered.

05/16/14: MRI Lumbar Spine report. IMPRESSION: At L5-S1, a laminectomy is present. Mild Modic type 1 fibrovascular endplate degenerative change is present, new as compared to previous exam. A 4-mm broad-based postoperative disc bulge is present with post curettage change in the annulus and enhancing granulation tissue in the left lateral recess and along the posterior lateral margin of the thecal sac. Mild enhancement of the descending left S1 root is present, suggesting left S1 neuritis. No residual or recurrent disc protrusion is seen.

05/19/14: The claimant was evaluated to review his MRI. His exam was unchanged. The plan was to begin physical therapy.

06/16/14: The Therapy Daily Note notes that the claimant stated he was very sore and hurting after his last visit. He stated that he hurt for about three days after and then it finally got better. He stated that he felt sore on this visit and may have slept wrong the previous night. On evaluation, it was noted that he had no increased discomfort with manual therapy or stretches that he completed that day. Most of his exercises were modified to prevent any increased discomfort.

06/19/14: The claimant was evaluated. It was noted that he was very frustrated regarding his lack of improvement. He felt that his symptoms had worsened. He noted that he had discomfort and radicular symptoms going down his right leg since his last visit. On exam, seated SLR was strongly positive at 35 degrees. 3+/5 gastrosoleus strength on the left. On the right, he had positive SLR at 25 degrees. Severe dysesthesias radiating down his posterior thigh to his toes bilaterally. Absent left Achilles reflex, 1+ on the right. Downgoing toes, no clonus. He was referred for EMG.

07/23/14: The claimant underwent EMG/NCV. The impression was chronic lumbosacral radiculopathy affecting predominantly the left S1 and to a lesser degree the left L5 nerve root.

07/23/14: The claimant was evaluated who recommended an anterior-posterior lumbar interbody fusion at L5-S1.

08/05/14: UR. RATIONALE: According to ODG, with the patient having undergone his previous lumbar procedure, and with his radicular symptoms which have not improved with conservative treatment, the requested APLIF with associated CPT codes would be considered medically appropriate in helping to stabilize his lumbar spine and functional ability. However, in the presence of epidural fibrosis, further surgery will not resolve the problem and potentially exacerbate it. In addition, the physician has requested an excessive number of inpatient length of stay hospitalization days. Patients undergoing lumbar fusion and under the posterior, anterior, or lateral approach are only supported for 3 days of inpatient hospitalization. I discussed the case with PA who indicated there was not any additional clinical information available to support this request at this time. Therefore, at this time, the request in its entirety cannot be supported.

08/27/14: UR. RATIONALE: While a surgical intervention may be considered, a recent preoperative psychological evaluation prior to lumbar spine fusion was not submitted for review. Also, there was no evidence in the medical reports submitted that the patient has exhausted conservative treatment such as corticosteroid injections prior to the proposed surgery. In agreement with the previous determination, the medical necessity of the request has not been substantiated.

09/10/14: The claimant was evaluated who noted that he had previously seen who stated on 07/26/14 "In my opinion, Mr. is a candidate not only for a new decompression procedure, but due to the fact that it this will be his third and he will also have evidence of motion segment instability, he is a candidate for a fusion." The claimant continued to describe severe pain and was requiring narcotic pain medication for relief. His exam continued to be remarkable for findings noted on previous exam. recommended an anterior-posterior lumbar interbody fusion at L5-S1.

10/03/14: The claimant was evaluated. On exam, he had posterior tenderness and paravertebral muscle spasm. SLR was positive at 30 degrees. He had painful flexion but normal range of motion of spine with very limited and painful extension. He had an antalgic gait favoring the RLE. On psychiatric exam, he had an inappropriate mood and affect – moderately depressed. He had decreased strength of 4/5 at L2-L3 on the left and decreased sensation from L3-S1 on the left. 1+ reflexes at S1 on the left compared to 2+ on the right. It was noted that he if was not approved for fusion surgery, he would be a good candidate for spinal cord stimulation trial. He was given Topamax and Norco.

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

The previous adverse decisions are upheld. There are no submitted x-rays or studies to document evidence of instability, and the claimant’s primary problem appears to be radiculopathy with weakness. He has a decreased left Achilles reflex and abnormal EMG. ODG does not recommend fusion under these conditions. A psychosocial screening was not submitted for review, which is required by the ODG. Additionally, five days length of hospitalization are not supported. Therefore, the request for IP APLIF @ L5-S1 2258 22845 22851 20930x2 20936x2 38220x2 22612 22840 with 5 days LOS is not medically necessary.

ODG:

Fusion (spinal)	<p><b>Patient Selection Criteria for Lumbar Spinal Fusion:</b>          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</p>
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	<p>and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (<a href="#">Andersson, 2000</a>) (<a href="#">Luers, 2007</a>)]</p> <p>(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. (<a href="#">Andersson, 2000</a>)</p> <p>(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.</p> <p>(5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability.</p> <p>(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 <a href="#">ODG Indications for Surgery -- Discectomy.</a>)</p> <p><b>Pre-Operative Surgical Indications Recommended:</b> Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; &amp; (2) All physical medicine and manual therapy interventions are completed; &amp; (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see <a href="#">discography criteria</a>) &amp; MRI demonstrating disc pathology correlated with symptoms and exam findings; &amp; (4) Spine pathology limited to two levels; &amp; (5) <a href="#">Psychosocial screen</a> with confounding issues addressed.</p> <p>(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. (<a href="#">Colorado, 2001</a>) (<a href="#">BlueCross BlueShield, 2002</a>)</p> <p>For average hospital LOS after criteria are met, see <a href="#">Hospital length of stay (LOS)</a>.</p>
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<p>Hospital length of stay (LOS)</p>	<p><b>ODG hospital length of stay (LOS) guidelines:</b></p> <p><b>Lumbar Fusion, posterior</b> (<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) -- 3 days  <i>Note: About 15% of discharges paid by workers' compensation.</i></p> <p><b>Lumbar Fusion, anterior</b> (<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) -- 3 days</p>
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	<p><b>Lumbar Fusion, lateral</b> (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>)  Actual data -- median 3 days; mean 3.8 days (<math>\pm 0.2</math>); discharges 15,125; charges (mean) \$89,088  Best practice target (no complications) -- 3 days</p> <p><b>Thoracic Fusion, posterior</b> (<i>81.05 - Dorsal and dorsolumbar fusion, posterior technique</i>)  Actual data -- median 6 days; mean 8.1 days (<math>\pm 0.2</math>); discharges 20,239; charges (mean) \$159,420  Best practice target (no complications) -- 5 days</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)