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Notice of Independent Review Decision

DATE: January 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5-S1 mini 360 w/foraminotomy, 2-day LOS 22558, 22851, 20931, 22612, 63047, 20937, 20926

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 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured when she was helping a customer, while working on xx/xx/xx.

07/22/13: The claimant was evaluated for low back pain. She stated that she had a work-related injury on 03/29/13 when she kneeled down and then arose. After sitting down, she could not walk. She had been treated with medications and attended 15 therapy sessions. It was mentioned that an MRI dated 06/07/13 revealed focal disc herniation at L5-S1 asymmetric to the left contacting the left S1 nerve root. She was scheduled for a left S1 epidural steroid injection and counseled regarding smoking cessation.

08/21/13: The claimant was reevaluated. She reported 80% pain relief following left S1 epidural steroid injection performed on 08/06/13 but reported that her calf remained tight and painful. Her tingling sensation in the left foot had diminished significantly. She reported a mild allergic reaction post injected. She reported taking Benadryl post injection and her symptoms resolved. The plan was for

observation for 30 days and continue care. A repeat ESI could be considered if her pain increased.

11/13/13: The claimant was evaluated. She was status post repeat left S1 ESI performed on 10/29/13 and reported 70-80% pain relief. She reported that her pain in her left foot was decreased. She reported that her pain was more localized to the left lower lumbar. She reported her leg pain had almost resolved. The plan was for observation for 30 days, continue care, consider medial branch blocks with progression to radiofrequency neurotomies, and increase to Neurontin 400 mg one in the morning, one in the afternoon, and two at bedtime.

02/05/14: The claimant was evaluated after 3rd left S1 epidural steroid injection on 01/21/14. She stated that she did not receive as much help out of that injection as previous ones. She felt like her low back pain was worse and that she had a knife in her left hip. She stated that she was having occasional muscle spasms in her left calf and occasional tingling in her left foot. She reported that compounded topical analgesic was effective for symptom control. She was scheduled for bilateral medial branch blocks at L4-L5 and L5-S1.

03/05/14: The claimant was evaluated after medial branch blocks at L4-L5 and L5-S1 performed on 02/25/14. She stated that she received 85% pain relief for the first three hours, and then her pain began to return. She stated that the pain was extending down both of her legs and keeping her up at night. She was to be scheduled for bilateral radiofrequency neurotomies at L4-L5 and L5-S1. She was given prescriptions for Norco 10/325 mg b.i.d. #60 and Elavil 10 mg 1 at bedtime #30.

04/02/14: The claimant was evaluated after bilateral radiofrequency neurotomies at L4-L5 and L5-S1 performed on 04/01/14 she reported her pain level to be 6/10 due to undergoing the procedure the day prior.

04/30/14: The claimant was evaluated. She reported the "brick" feeling to the left buttock was gone, though she continued to experience intermittent left leg pain. referred her for return to work evaluation with FCE for consideration of return to work or return to work retraining program which as work hardening.

08/05/14: MRI L Spine w/o Contrast report. FINDINGS: No evidence for active pathology is seen involving the bony pelvis or hips. The lumbar spine itself is normally aligned without fracture or distinct bone lesion. The conus and intrathecal structures appear within normal limits. The discs appear to have only minimal degenerative change down to the L4-L5 level. Minor broad-based posterior disc protrusion is seen at L4-L5 without substantial neural foraminal or spinal stenosis. Small disc protrusion centrally with small annular tear is noted at the L5-S1 level. This contacts the thecal sac and S2 roots but does not appear to compress them overtly. No other abnormalities are identified. IMPRESSION: 1. Only minor degenerative changes are seen down to the L4-L5 level and L4-L5 shows only a minor central disc protrusion. 2. L5-S1 shows a slightly more prominent but still relatively small focal disc protrusion centrally. This contacts

both S1 nerve roots but does not appear to grossly compress them. Correlation is needed clinically. The study is otherwise unremarkable.

08/20/14: The claimant was evaluated. She had completed 20 sessions of work conditioning. She continued to work part time on light duty, which she states she was asked to move shoes and reach overhead which increased her pain. She was currently taking Norco 10 mg b.i.d., Flexeril 10 mg q.h.s., and Neurontin 1200 mg daily. She was prescribed Ultram for breakthrough pain which made her sick, so she discontinued it. She was requesting increasing her Norco 10 mg from b.i.d. to t.i.d. She was referred for surgical consultation.

08/29/14: The claimant was evaluated for low back and leg pain. She stated that her pain was worse at night and woke her from sleep. She had difficulty standing, walking, rising from a chair, and physical activity. She had tried physical therapy decompression, injections, rhizotomy, and medications, but it was noted that she continued to have severe pain. Her medications included cyclobenzaprine, gabapentin, Amitriptyline, and hydrocodone/acetaminophen. She was a current smoker and smoked 2 packs of cigarettes per day. On exam, She had good range of motion of her upper and lower extremities with good peripheral pulses present. DTRs were 2, equal and symmetric. No long tract signs were seen. Negative Romberg's sign. Negative Hoffman's sign. Negative Babinski's. Negative reverse radial reflex. Normal gait pattern. Upper and lower extremity motor strength was graded 5/5 except for dorsiflexion bilateral at L4 and 5. She stood with a forward-flexed posture. Negative for pelvic obliquity. There was significant spinal tenderness in the paraspinal muscles. Bilateral straight leg raise was slightly positive, reproducing leg pain. There were no Waddell signs present. There was a negative Spurling's test and negative Lhermitte's sign. She demonstrated poor range of motion with flexion, extension, side bending, and rotation. Spinal motion was with pain. AP, lateral, and flexion/extension views were performed in the office on this date demonstrating 5 mobile lumbar segments. Pedicles were well visualized. Normal appearance to the SI joints. Normal appearing vertebral bodies. There was no instability seen. There was a normal appearance to the discs except for disc space narrowing at L5-S1. MRI review: Radiologist findings noted with the following modifications: Significant changes seen in the disc at L5-S1 with disc space narrowing. Disc desiccation and slight Modic changes. There is also foraminal stenosis bilateral causing compression of the L5 nerve. assessment was low back pain and bilateral lower extremity pain with weakness, sensory loss secondary to work-related injury changes occurring at the L5-S1 disc with foraminal stenosis and nerve root compression causing low back pain and radiculopathy. It was noted that she had failed PT, chiropractic therapy, medication management, pain management, and injections and continued to have persistent unrelenting pain in her low back and legs. recommended surgery for a decompression at L5-S1 with surgical stabilization with fusion. She was counseled regarding smoking cessation. She would need a medical and cardiac clearance prior to surgery.

09/09/14: The claimant underwent a psychological evaluation, and was cleared for surgery from a psychological standpoint.

09/17/14: The claimant was evaluated. On exam, she had bilateral lumbar paraspinal tenderness with palpation. SLR was positive on the left. Lumbar AROM was restricted and painful with increased pain noted on hyperextension and bilateral side bending. Left sacroiliac joint was tender with palpation. She had normal muscle strength and tone. Sensation was diminished in the left L5-S1 dermatomes. She was to continue with her current medications and return in one month. She was given prescriptions for Norco 7.5/325 mg t.i.d. #90, Elavil 10 mg 1 q.h.s., Neurontin 300 mg, and Flexeril 10 mg.

10/28/14: UR. RATIONALE: The patient has radicular symptoms despite appropriate conservative treatment. However, interpretation of the MRI differs from the formal report. identified significant changes seen in the disc at L5-S1 with disc narrowing, and bilateral foraminal stenosis with L5 nerve compression. The formal MRI report identified only minor degenerative changes seen down the L4-L5 level. At L5-S1, there is a relatively small focal disc protrusion centrally which contracts both S1 nerve roots but does not appear to grossly compress them. The surgical procedure cannot be certified in light of such discrepancies. The MRI did not reveal significant nerve root pathology. In addition, ODG states that until further research is conducted, there remains insufficient evidence to recommend fusion for chronic low back pain in the absence of stenosis and spondylolisthesis, and this treatment for this condition remains "under study." There is no indication for a fusion procedure. There are no signs of instability. Recommend non-certification.

12/04/14: UR. RATIONALE: In this case, the clinical documentation did not support a one-level fusion 360 degree at L5-S1 with foraminotomy. Imaging studies provided for review did not identify and clear evidence of nerve root compression at L5-S1 which would explain the bilateral dorsiflexion weakness on physical examination. No radiological addenda were made available for review. The patient failed a reasonable course of conservative treatment. However, without evidence of any significant instability or degenerative disc disease contributing to nerve root compression on MRI, surgical intervention including fusion and foraminotomy would not be supported as medically appropriate. The patient had a two pack per day smoking habit. counseled the patient on smoking; however, it is unclear if the patient was compliant with smoking cessation. Guidelines recommend that patients be smoke free for at least six weeks prior to any surgical considerations. Furthermore, the last clinical evaluation was from 08/14, and there are no updated evaluations from the requesting physician to support surgical intervention. Therefore, this reviewer would not recommend certification for the request at this time and the prior denials remain upheld. As the surgical request for this patient is not indicated, there would be no requirement for the requested 2 day length of stay. I spoke with, and the case was discussed. Per our discussion, he indicated that he would fax over further imaging showing instability at L5-S1. At the time of submission, no additional information was provided for review. As such, the determination remains unchanged.

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

The previous adverse decisions are upheld. The August 2014 MRI of the lumbar spine did not demonstrate significant disc disease. A minor central disc protrusion at L4-5 and a small disc protrusion at L5-S1 were identified in this study. The disc protrusion at L5-S1 was associated with a small annular tear and no significant nerve compression. These MRI findings do not explain the claimant's radicular symptoms. An EMG-NC study would be required to confirm radiculopathy associated with the L5-S1 level before consideration of surgery at this level.

The Official Disability Guidelines (ODG) supports lumbar spinal fusion in the setting of segmental instability. This claimant has no documentation of lumbar spine instability at L5-S1. Therefore, the request for L5-S1 mini 360 w/foraminotomy, 2-day LOS 22558, 22851, 20931, 22612, 63047, 20937, 20926 is not medically necessary.

ODG:

Fusion (spinal)	<p>Patient Selection Criteria for Lumbar Spinal Fusion:</p> <p>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.)</p> <p>Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1)</p>
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	<p>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>
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<p>Discectomy/ laminectomy</p>	<p><u>ODG Indications for Surgery™ -- Discectomy/laminectomy --</u></p> <p>Required symptoms/findings; imaging studies; & conservative treatments below:</p> <p>I. <u>Symptoms/Findings</u> which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.</p> <p>Findings require ONE of the following:</p> <ul style="list-style-type: none"> A. L3 nerve root compression, requiring ONE of the following: <ul style="list-style-type: none"> 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain B. L4 nerve root compression, requiring ONE of the following: <ul style="list-style-type: none"> 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness 3. Unilateral hip/thigh/knee/medial pain C. L5 nerve root compression, requiring ONE of the following: <ul style="list-style-type: none"> 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain D. S1 nerve root compression, requiring ONE of the following: <ul style="list-style-type: none"> 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 3. Unilateral buttock/posterior thigh/calf pain <p>(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)</p> <p>II. <u>Imaging Studies</u>, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:</p> <ul style="list-style-type: none"> A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis <p>Diagnostic imaging modalities, requiring ONE of the following:</p>
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	<ol style="list-style-type: none"> 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-Ray <p>III. <u>Conservative Treatments</u>, requiring ALL of the following:</p> <p>A. Activity modification (not bed rest) after patient education (≥ 2 months)</p> <p>B. Drug therapy, requiring at least ONE of the following:</p> <ol style="list-style-type: none"> 1. NSAID drug therapy 2. Other analgesic therapy 3. Muscle relaxants 4. Epidural Steroid Injection (ESI) <p>C. Support provider referral, requiring at least ONE of the following (in order of priority):</p> <ol style="list-style-type: none"> 1. Physical therapy (teach home exercise/stretching) 2. Manual therapy (chiropractor or massage therapist) 3. Psychological screening that could affect surgical outcome 4. Back school (Fisher, 2004)
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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 (mean) \$89,088 Best practice target (no complications) -- <i>3 days</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)**