



**MEDICAL EVALUATORS
OF TEXAS ASO, LLC.**

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Notice of Independent Review Decision

January 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X-ray of the lumbar spine

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

This case was reviewed by a physician who holds a board certification in Orthopaedic Surgery. The reviewer is currently licensed and practicing in the state of Texas.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overtured (Disagree)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury to her low back on xx/xx/xx due to a fall, prior treatment includes physical therapy, chronic pain therapy program, multiple ESIs, facet blocks followed by rhizotomy that was ineffective, and numerous trigger point injections with no long term response.

On 04/15/2014, the patient underwent bilateral L5-S1 re-exploration lumbar laminectomy, total left L5-S1 facetectomy, partial right L5-S1 facetectomy, excision of recurrent herniated disk, external neurolysis of the left S1 nerve root and thecal sac, radical L5-S1 discectomy, transforaminal lumbar interbody fusion at the L5-S1 level with autograft bone from the right iliac crest, placement of pioneer peek interbody fusion cage at L5-S1 level, lateral gutter fusion at the L5-S1 level bilaterally with autograft bone, posterior instrumentation of the lumbar spine L5 to S1 with pioneer streamline pedicle screws and rods, preparation of posterior element bone for use in lumbar fusion, bone marrow harvest, right iliac osteotomy, right iliac crest reconstruction, fluoroscopic localization and guidance, and intraoperative neurophysiologic monitoring. The procedure was performed.

The patient was seen for follow up on 05/12/2014; examination revealed a healing incision with some tenderness to the upper incisional area, and DTRs were 1+. The patient was



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diagnosed with status post L5-S1 PLIF dated 04/15/2014, and small indurated hematoma at the incisional site. She was recommended to start physical therapy, and X-ray of the lumbosacral spine was performed on the day of the visit and revealed that the cage and screws are in excellent position at L5-S1, there were no lucencies, and it showed excellent bone density in the disc space and lateral gutters.

On 07/09/2014, the patient was seen again for a follow up; examination revealed a well healed incision, diffuse tenderness around the donor site, no trigger points were palpable, and DTRs were 1+. She was diagnosed with residual lower back pain status post L5-S1 PLIF dated 04/15/2014, and the physician recommended active physical therapy 3 times a week for 4 weeks, and gave the patient for her myofascial pain, 10% flurbioprofen, 6% gabapentin, 3% cyclobenzaprine, and 1% bupivacaine. She also had another X-ray of the lumbosacral spine which revealed that the cage and screws are in excellent position at L5-S1 without movement on flexion and extension, there were no lucencies, and it showed excellent bone density in the disc space.

The patient was seen back on 09/03/2014, examination revealed a well healed incision, diffuse tenderness around the donor site, no trigger points were palpable, and DTRs were 1+. She was diagnosed with residual lower back pain status post L5-S1 PLIF dated 04/15/2014, and the physician recommended the patient to continue her physical therapy. Another X-ray of the lumbosacral spine was performed and revealed no movement on flexion and extension, there were no lucencies, and it showed excellent bone density in the disc space.

On 10/29/2014, the patient came back for a follow up; examination revealed a well healed incision, positive twitch response bilaterally to the lower lumbar spine, palpable trigger points, and DTRs were 1+. She was dated 04/15/2014, and trigger points X2 to the lumbar spine. The physician recommended the patient to continue her physical therapy and current medications, and performed a repeat X-ray of lumbosacral spine which revealed that the cage and screws are in good position at L5-S1 with excellent bone density in the disc space, there were no movement on felxion and extension, and there were no lucencies.

UR letter has denied to cover the service of "X-ray exam of the lumbar spine" because there was no report of a new acute injury or exacerbation of previous symptoms following the 10/29/2014 X-rays, there was no mention that surgical intervention was anticipated, and there were no redflags identified that would warrant a repeat study.



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

This female underwent a single level lumbar fusion in April of 2014. She had no complications during this surgery. It is routine practice to image these patients at 1, 3, 6, and 12 months to assess the level of fusion. According to the Official Disability Guidelines (ODG), x-rays should be approved during post-surgery to evaluate status of fusion.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Allogeneic morphogenetic protein vs. recombinant human bone morphogenetic protein-2 in lumbar interbody fusion procedures: a radiographic and economic analysis; Jeffrey S Roh1*, Christopher A Yeung2, Justin S Field2 and R Trigg McClellan; *Journal of Orthopaedic Surgery and Research* 2013, **8**:49 doi:10.1186/1749-799X-8-49

Abstract:

“Three hundred twenty-one (321) patients from three centers underwent a transforaminal lumbar interbody fusion (TLIF) or lateral lumbar interbody fusion (LLIF) procedure and were assessed by an independent radiologist for fusion and radiographically evident complications. The independent radiologist was blinded to the intervention, product, and surgeon information. Two hundred and twenty-six (226) patients received OsteoAMP with autologous local bone, while ninety-five (95) patients received Infuse with autologous local bone. Patients underwent radiographs (x-ray and/or CT) at standard postoperative follow-up intervals of approximately 1, 3, 6, 12, and 18 months. Fusion was defined as radiographic evidence of bridging across endplates, or bridging from endplates to interspace disc plugs.”

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG - Low back – Lumbar & Thoracic (Acute and Chronic) (online version)

Radiography:

Not recommend routine x-rays in the absence of red flags. (See indications list below.) Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. However, some providers feel it “may” be appropriate when the physician believes it would aid in patient expectations and management. The theory is that this reassurance may lessen fear avoidance regarding return to normal activities and exercise, but this has not been proven. (Ash, 2008) Indiscriminant imaging may result in false positive findings that are not the source of painful symptoms and do not warrant



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surgery. A history that includes the key features of serious causes will detect all patients requiring imaging. (Kendrick, 2001) (Bigos, 1999) (Seidenwurm, 2000) (Gilbert, 2004) (Gilbert2, 2004) (Yelland, 2004) (Airaksinen, 2006) (Chou, 2007) According to the American College of Radiology, "It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies." (ACR, 2000) A Recent quality study concludes that MRI is no better than x-rays in management of low back pain, if the cost benefit analysis includes all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) The new proposed HEDIS (Health plan Employer Data Information Set) report card on the use of imaging for low back is scheduled to go into effect on Jan 1, 2005. This new standard is the first one in which the issue is over utilization. In young and middle-aged adults, with new episodes of mechanical LBP, without any indication of comorbid complications, the new standard assumes that there is no indication for imaging. (HEDIS, 2004) The new ACP/APS guideline as compared to the old AHCPR guideline is similarly cautious about the use of plain x-ray imaging, but now more strongly supported by the availability of randomized trials showing no benefit for early x-ray imaging. (Shekelle, 2008) New research shows that healthcare expenditures for back and neck problems have increased substantially over time, but with little improvement in healthcare outcomes such as functional disability and work limitations. Rates of imaging, injections, opiate use, and spinal surgery have increased substantially over the past decade, but it is unclear what impact, if any, this has had on health outcomes. (Martin, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009) Routine imaging for low back pain is not beneficial and may even be harmful, according to new guidelines from the American College of Physicians. Imaging is indicated only if patients have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms. (Chou, 2011) The recommendation to avoid early imaging for low back pain was included in the National Physicians Alliance's list of Top 5 Health Care Activities for Which Less Is More. (Srinivas, 2012) See also ACR Appropriateness Criteria™. See also Flexion/extension imaging studies.

Indications for imaging -- Plain X-rays:

- Thoracic spine trauma: severe trauma, pain, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma (a serious bodily injury): pain, tenderness
- Lumbar spine trauma: trauma, neurological deficit



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- Lumbar spine trauma: seat belt (chance) fracture
- Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70
- Uncomplicated low back pain, suspicion of cancer, infection
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, painful
- Myelopathy, sudden onset
- Myelopathy, infectious disease patient
- Myelopathy, oncology patient
- Post-surgery: evaluate status of fusion