Vanguard MedReview, Inc.

4604 Timken Trail
Fort Worth, TX 76137
P 817-751-1632
F 817-632-2619

March 7, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
3 Days Inpatient Hospital Admission, L4-5 Minimally Invasive Transforaminal Lumbar Interbody Fusion 22840, Anterior Lumbar Interbody Fusion L4-5 22558, 22845, 22854

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This case was reviewed by a Board Certified Orthopedic Surgeon with over 40 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]:

This claimant is a male who was injured at work on XX/XX/XX. He was driving and was hit by a truck.

XX/XX/XX: Electro diagnostic Study Report. **Summary and Impression:** 1. Abnormal Study 2. The electrodiagnostic study is consistent with a chronic left S1 radiculopathy. 3. The right tibial H reflex was not obtainable. This may be the only abnormal finding in a mild right S1 sensory radiculopathy. However, it is a nonspecific abnormal finding that can be found with a lesion that affects any portion of the Achiles deep tendon reflex pathway. The right lower extremity needle EMG portion of the examination was normal. 4. There was no electrodiagnostic evidence for a left cervical radiculopathy, left brachial plexopathy, or for a neuropathy involving any of the nerves that were tested.

XX/XX/XX: Initial Evaluation. **Subjective:** Patient was injured on XX/XX/XX and went to ER a few days after injury and was given medication. He later consulted with his physician. And then consulted with XX. He states that he has had x-rays, MRI, and nerve testing. He has not been able to work since XX/XX/XX. He states that medical history includes a lumbar surgery in XXXX (He states he did very well after that surgery and has not had problems until this recent injury). He states he is taking pain medication and is also on medication for his blood pressure. He is not currently doing any exercises or using any heat/ice. The patient underwent 2 physical therapy treatments in this facility in XX/XXXX but discontinued the treatments at the recommendation of XX because of the increased pain with even gentle exercise attempts. Today, the patient states he had to go to the ER in January because of severe pain. He states he underwent a CT scan and was placed on steroids. He is scheduled for lumbar injections for XX/XX/XX. He currently complains of bilateral upper cervical pain, L>R trapezius pain, bilateral

lumbar pain, L>R to his fingers, left hand numbness, finger cramping/stiffness, and L>R pain (mostly posterior-lateral) to his toes. He is having sleeping difficulties because of pain. Pain is increased with lying down, sitting, driving, standing, and increased activity levels. **Objective:** Posture: forward head, rounded shoulders, increased thoracic spine kyphosis, and reduced lumbar lordosis. Gait: no assistive device, reduced trunk rotation, and reduced arm swing. Lumbar AROM: flexion: 50 (moderate pain increase) 11 (significant pain increase) Rt. Lf: 21 (moderate pain increase), Lt LF: 16 (moderate pain increase). **Assessment:** The patient presents with the diagnosis of cervical strain, lumbar HNP/ disc protrusion, S1 radiculopathy, and cervical disc protrusions/stenosis. Short term goals: 1. The patient is educated regarding proper posture and body mechanics. 2. Reduce pain spasms and tenderness. 3. Inverse cervical and lumbar AROM. 4. Increase strength and flexibility of involved musculature.

XX/XX/XX: Office Visit. **Chief Complaint:** XX complains of neck pain and low back pain. He also complains of frequent headaches and numbness. He had a #1 TF-ESI Bilateral L4-5 done XX/XX/XX. He states he received 25% improvement for about 2-3 weeks and he was able to get out and work. He has been mowing and fixing fences. He says that he believes he over did it with working. He would like to try the ESI again. Pain: Current-4 Best-4, worst-7 over last 30 days. **Current Meds:** Ultram 50 mg ii po TID, Neurontin 600 mg I po bid and I ½ po QHS, Lisinopril 40 mg I po qd. He has been treated with physical therapy, pain meds, ice, heat and TENS unit. **Diagnosis:** L-spine sprain, c-spine sprain, T-spine sprain, protrusions at L2-3, L3-4, L4-5, L5-S1 and stenosis at L4-5, L5-S1 **Plan:** Recommendations are repeat TF-ESI Bilateral L4-5, decadron 4 mg po qid x 2 days #8, follow up 1 month.

XX/XX/XX: Open MRI L-Spine w/o contrast. **Impression:** 1. Degenerated narrow L4-L5 disc. Right paracentral protrusion compressing the thecal sac and narrowing the canal. A displaced right L5 nerve root. Correlate clinically. Facet arthrosis present at this level. 2. Desiccated L5-S1 disc. Mild foraminal narrowing. 3. Mild to moderate facet arthrosis.

XX/XX/XX: Open MRI C-Spine W/O contrast. **Impression:** 1. straightening of the normal cervical lordosis. No subluxation. 2. C5-C6 right sided disc protrusion compromising the medial aspect of the right foramen. Correlate clinically with regard to symptoms. 3. Small central posterior protrusion at C3-C4 and C4-C5. May slightly efface the cord at the C3-C4 level.

XX/XX/XX: Operative Report: Right Sided redo hemilaminotomy and microscopic discectomy with a transpedicular type approach. **Postoperative diagnosis:** Recurrent herniation at L4-5

XX/XX/XX: OR Spine 1 View. **Impression:** L4-L5 posterior localization, intraoperatively

XX/XX/XX: Office Note. **Notes:** Chief complaint is continued low back pain. He still has some shooting pain down his right leg but it is not as constant as it was so I think overall he is better. He also still has pending cervical injury that there is some dispute on that he wants me to look at. I believe he did need surgery for his cervical spine but unfortunately so far the WC has had it under dispute. So for now we are going to keep him out of work. We will see him back in 3 months. He said that he would have XX do some exercise therapy on him down there in XX. Since that is so far way I will let XX work on that. He will need some lumbar stabilization, strengthening, and work hardening before he goes back to work but, again, his neck needs to be fixed as well.

XX/XX/XX: Follow Up appointment. **HPI:** XX is status post an L4-L5 hemilaminectomy discectomy XX/XX/XX. He continues to complain of intermittent moderately severe sciatica, numbness, and dysesthesias in bboth lower extremities. The pain is aggravated by sitting 15 minutes, driving 15 minutes, prolonged standing, twisting, bending, stooping, lifting and relieved by lying supine. He just started pt as part of his post-surgical treatment. He continues to take Norco, Gabapentin, and Amitriptyline, which are helping to relieve over 50% of his pain and improve functions. XX continues to complain of very severe intermittent aching neck pain radiating down both upper extremities associated with numbness and paresthesias in the arms aggravated by neck motions and is relieved by lying supine. **Physical Exam:** Lumbar spine AROM: Flexion 25% of full. Extension limited to 0° neutral. Mild discomfort with lumbar spine flexion and extension motions. Tenderness to palpation over the cervical spine. Cervical spine AROM: Flexion 75% of full, extension 50% of full. Increased pain with cervical spine

extension motions. Otherwise Inspection/Palpation/ROM/stability of the extremities is within normal limits. **Assessment:** 1. Work related injury XX/XX/XX. The initial accepted WC diagnosis are cervical strain and lumbar strain. 2. L4-L5 herniated nucleus pulposus causing central canal stenosis and neuroforaminal stenosis. 3. Bilateral L5-S1 lumbosacral radiculopathy. 4. Status post hemilaminectomy/microscopic discectomy at the L4-L5 level XX/XX/XX. 5. Large C5-C6 disc protrusion that has gradually increased in size on serial imaging studies of the cervical spine. 6. Bilateral C5-C6 cervical radiculopathy. 7. Comorbidities: Mild C3-C4, C4-C5, C5-C6 retrolisthesis on cervical extension views that corrects to neutral on cervical flexion views without significant instability. Although there is no significant instability, the mild motion at these levels can certainly be contributing to his chronic neck pain. **Plan:** 1. Continue pt which include lumbar spine stabilization exercises for a grand total of 16 sessions. 2. Norco to 7.5/325 mg 1 po TID prn pain #45 No refills. 3. Gabapentin 600mg tab 1 po bid, 2 po qhs #60. No refills. 4. Amitriptyline 10mg 1 po qhs #15. No refills. 5. Activity restrictions: No lifting over 20 pounds, avoid bending, twisting, stooping activities more than 6 times per hour. No pushing or pulling over 50 pounds hand force. 6. 6 panel quantitative urine drug screen. 7. Follow up appointment with me XX/XX/XX.

XX/XX/XX: Follow Up Appointment. **HPI:** XX continues to complain of intermittent moderately severe sciatica, numbness and dysesthesia in both lower extremities. He completed 3 sessions of physical therapy. He feels that pt is aggravating his low back pain and sciatica. For this reason, he has decided to discontinue pt. XX continues to complain of very severe intermittent aching neck pain radiating down both upper extremities associated with numbness and paresthesias in the arms aggravated by neck motions and is relieved by lying supine. **Physical Examination:** Lumbar spine AROM: Flexion 25% of full. Extension limited to 0° neutral. Mild discomfort with lumbar spine flexion and extension motions. Tenderness to palpation over the cervical spine. Cervical Spine AROM: Flexion: 75% of full, extension 50% of full, increased pain with cervical spine extension motions. **Assessment:** 1. Work related injury X/XX/XX . The initial accepted work comp diagnoses are cervical strain and lumbar strain. 2. L4-L5 herniated nucleus pulposus causing central canal stenosis and neuroforaminal stenosis. 3. Bilateral L5 S1 lumbosacral radiculopathy. 4. Status post hemilaminectomy/microscopic discectomy at the the L4-L5 level XX/XX/XX.5. Large C5-C6 disc protrusion that has gradually increased in size on serial imaging studies of the cervical spine. 6. Bilateral C5 C6 cervical radiculopathy. 7. Comorbidities: Mild C3-C4, C4-C5, C5-C6 retrolisthesis on cervical extension views that corrects to neutral on cervical flexion views without significant instability. Although there is no significant instability the mild motion at these levels can certainly be contributing to his chronic neck pain. **Plan:** 1. Norco to 7.5/325 mg 1 po TID prn pain #45. No refills 2. Gabapentin 600 mg 1 po BID, 2 po QHS #60. No refills. 3 Amitriptyline 10mg 1 po QHS #15. No refills. 4. Activity restriction: No lifting over 20 pounds, avoid bending, twisting, stooping activities no more than 6 times per hour. No pushing or pulling over 50 pounds hand force.

XX/XX/XX: AZA Hybrid Exam. **Notes:** Patient is about 5 months status post redo microdiskectomy at L4-5. Of note, he had come previously with a previous surgery in early XXXX for a herniated disk. We did a redo microdiskectomy on him in XX and after that surgery, he really did not improve much. Also, he has a cervical herniated disk with some cervical stenosis that was denied by WC and is in dispute. I had actually recommended a cervical fusion as well. He does have absent Achilles tendon reflexes bilaterally. He has normal patellar tendon reflexes. He is grossly neurologically intact in his lower extremities, except he has a positive straight leg raise bilaterally. As far as his upper extremities, he is strong as far as 5/5 strength, but he does have mild hyperreflexia in his upper extremities. **Impression:** Post discectomy syndrome, slight lateral listhesis, possible spinal stenosis. **Plan:** At this point, since the MRI was denied, I would recommend a myelogram plus CT of the lumbar spine. If that should be denied, he may be a candidate for a diskogram. He needs an anterior cervical discectomy and fusion. He may need an L4-5 fusion at some point.

XX/XX/XX: CT L Spine w/ contrast. **Impression:** L4-5 Mild degenerative disk disease at L4-L5 with evidence of prior right hemilaminaectomy. Mild posterior disc osteophyte complex. There is mild left and moderate right neural foraminal stenosis. No spinal canal stenosis.

XX/XX/XX: XR Myelography, Lumbosacral. **Impression:** Uncomplicated fluoroscopy guided intrathecal injection for CT lumbar myelogram.

XX/XX/XX: AZA Hybrid Exam. **Notes:** The myelogram does confirm degenerative disk disease at the L4-5 level with normal disc above and below. The canal itself looks patent. I do not see a recurrent herniation or any stenosis on these films. He does have some narrowing, however, of the L4-5 foramen and narrowing of the L4-5 disc. Again, he had 2 discectomies at the L4-5 level. He still has severe back pain going down bilateral legs when he ambulates any distance. He also has a positive straight leg raise bilaterally and absent Achilles tendon reflexes bilaterally, but symmetric and normal strength bilaterally. At this point, my impression is he probably has discogenic pain and possible foraminal stenosis at L4-5. The only way to fix that would be a fusion. I would like to do a diskogram for evaluation and whether he is a candidate for a fusion, and that is what I am going to order. Will see him back after.

XX/XX/XX: Office Note. **Note:** We had ordered a diskogram on him. He has degenerative disk disease at L4-5 on CT myelogram. He has had a redo micro disk there twice. The diskogram was denied. I reviewed his films again and on the axial slices it does look like he possibly has an interior facet fracture on the right side at L4-5 and they have denied his diskogram. The other disks look completely normal. He has no true central stenosis, although he probably does have some foraminal stenosis at 4-5 on that side. Particularly at this point, due to the possibility of an inferior facet fracture, the severe degenerative nature of the 4-5 disk, and he has already had discectomy and they are denying the diskogram for more information, which would be nice, I am recommending a fusion of L4-5, I would recommend an ALIF versus a minimally invasive TLIF fusion on him and we will go ahead and put that through to see if they would approve that.

XX/XX/XX: UR. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non-certified. The clinical documentation submitted for review did not identify failure of recent conservative efforts to include injections, physical therapy, or medication use. The clinical documentation also did not include a pre-operative psychological evaluation ruling out any confounding issues that would potentially delay recovery.

XX/XX/XXX: UR **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines, this request is non certified based on lack of appropriate physical examination and imaging findings and lack of appropriate psychological screening.

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

The previous adverse determinations are upheld. Before considering recommendation for spinal fusion anterior and posterior I would need up to date history and physical exam as well as up to date surgical plan. ODG does not recommend lumbar fusion for treatment of degenerative disc disease brought about by a workers comp injury. Based on the existing records of xxxxxx I do not recommend a 360 fusion at L-4-5 on this patient.

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)**