Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 04/21/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L2-S1 transforaminal lumbar interbody fusion with L1-L2 laminectomy with a 1-2 inpatient length of stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> of the health care services in dispute.

L2-S1 transforaminal lumbar interbody fusion with L1-L2 laminectomy with a 1-2 inpatient length of stay – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
A lumbar MRI was obtained on XX/XX/XX and revealed postsurgical changes along the posterior elements of L3, L4, and L5 probable complete laminectomy at L5 and partial laminectomy or complete laminectomies with scarring at L3-L4 and L4-L5. There was multilevel degenerative disc disease with prominent bulging annuli with a mild central canal stenosis at L2-L3. At L4-L5, there was substantial narrowing of the thecal sac and it was unclear if this was related to epidural scarring from the surgery or remaining central stenosis since the done

details were limited in that area. Additional narrowing was noted at L3-L4 and accompanied by a broad based disc bulge. There was mild anterior subluxation of L4 on L5. XX examined the patient on XX/XX/XX. His current medications were Lisinopril, Hydrochlorothiazide, Levothyroxine, Gemfibrozil, Metformin, Diclofenac, and Misoprostol. He was 69 inches tall and weighed 235 pounds. He was injured on XX/XX/XX when he fell over metal parts at work and subsequently underwent laminectomy at multiple levels. He noted about three years prior he began noticing recurrent pain that worsened on the left than the right with pain radiating to the left leg with numbness and pain in the buttocks. ESIs had been recently requested, but denied. He currently had numbness in the left leg and foot and some difficulty ambulating. The MRI was reviewed. He was noted to be a four cigar smoker daily. Sensation was decreased over the left leg and dorsum of the left foot. Tinel's was positive over the right elbow at the ulnar nerve surgery site. SLR was 60 degrees bilaterally and he had muscles spasms on the left. He had good power in his extremities, except for some decreased performance in the left lower extremity. The assessment was lumbar stenosis particularly at L4 with anterolisthesis at that level and a degree of stenosis at L2-L3 and L3-L4, above the levels of his previous surgery. A lumber CT myelogram was recommended, as well as flexion/extension x-rays. It was noted he might need a fusion at L4-L5. Lumbar x-rays dated XX/XX/XX revealed desiccation at all the lumbar disc spaces, most significant and severe at L4-L5. There were bilateral decompressive laminectomies at L3-L4 and L4-L5. There was 3 mm. of retrolisthesis of L2 on L3 and L3 on L4, 1 cm. of retrolisthesis of L4 on L5, and 3 mm. of anterolisthesis of L5 on S1 without pars defects identified at any of those levels secondary to facet joint hypertrophy at all the levels. There was no change when comparing the neutral and lateral flexion and extension images. A lumbar CT myelogram was also obtained that day. There was a 1 mm. diffuse annular bulge at T11-T12 without central stenosis and moderate bilateral facet joint hypertrophy was noted. At T12-L1, there was a 3 mm .right posterolateral disc and mild bilateral facet joint hypertrophy. At L1-L2, there was spinal stenosis and the thecal sac measured 9 mm. within the midline secondary to a 33 mm .right paracentral broad-based disc and mild bilateral facet joint hypertrophy. There was spinal stenosis at L2-L3 and the thecal sac measured 9 mm .within the midline secondary to a 3 mm. retrolisthesis, uncovering of the disc, and a 3 mm. broad based disc, and moderate bilateral facet joint hypertrophy narrowing the bilateral lateral recesses and proximal bilateral neural foramen. At L3-L4, there was decompressive laminectomy bilaterally and a 3 mm. retrolisthesis, uncovering of the disc, and a 3 mm. broad based disc protrusion narrowing the bilateral lateral recesses and proximal bilateral neural foramina without central stenosis. The thecal sac still measured 1 cm. within the midline. There was central stenosis with the thecal sac measuring 4 mm .at L4-L5 within the midline secondary to a 1 cm. anterolisthesis of L4 on L5, uncovering of the disc, a superimposed 7 mm. far left lateral and broad based disc protrusion, and severe bilateral facet joint hypertrophy narrowing the bilateral lateral recesses and proximal bilateral neural foramina. At L5-S1, there was a 6 mm. broad based disc and severe bilateral facet joint hypertrophy

narrowing the bilateral lateral recesses and proximal bilateral neural foramina. Desiccation was identified at all lumbar disc spaces, but was most significant and severe at L4-L5. XX examined the patient on XX/XX/XX. He had undergone recent right ulnar decompression and right carpal tunnel surgery recently. His last HgbA1c 5 and he smoked four small cigars a day. He noted he had leg pain with walking, weakness, numbness, tingling, and loss of muscle bulk. He had full active ROM, but the body part was not specified. He ambulated without difficulty and had no joint swelling. Strength was 5/5 in the bilateral upper extremities. No sensory deficits were noted. Lower extremity strength was 5/5 in the bilateral lower extremities, except for the right hip flexors at 4/5. All DTRs were 2+ bilaterally. He had a steady, but antalgic gait. The lumbar MRI and CT myelogram were reviewed. The diagnoses were spondylolisthesis of lumbar region, facet hypertrophy of lumbosacral region, lumbosacral degenerative disc disease, and lumbar stenosis with neurogenic claudication. XX stated given the signs and symptoms, surgery in the form of L2-S1 transforaminal lumbar interbody fusion and L1-L2 laminotomy would be appropriate. The risks and benefits were discussed. On XX/XX/XX, a preauthorization request was submitted for the lumbar surgery. XX provided an adverse determination on XX/XX/XX for the requested lumbar surgery. Another preauthorization request was submitted on XX/XX/XX and XX provided another adverse determination on XX/XX/XX. Per the XX/XX/XX, prospective IRO review response, the requested procedure was not approved, as there were no corroborated physical findings and imaging studies, lack of psychological screening, no smoking cessation program, and no documentation of failure of lower levels of care.

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

The patient appears to be suffering from degenerative disc disease and spinal stenosis. There is no objective evidence of instability presented. Retrolisthesis alone is not an indication for lumbar fusion. There are no flexion/extension x-rays to document that there is instability of a significant magnitude for which surgical intervention is indicated. Radiculopathy has also not been objectively documented or supported. Furthermore, there is no documentation of smoking cessation, which, given the length of fusion being requested, would be mandated. There is no documentation of the appropriate presurgical psychosocial screening, as required by the ODG. In addition, there is no evidence that an extensive fusion is going to improve the patient's function or relieve his pain. There are no objective neurological findings for which a decompressive laminectomy would be authorized without reflex change, sensory change, or motor change. There has been insufficient treatment with conservative modalities for either a fusion or a laminectomy/decompression, including epidural steroid injections (ESIs), physical therapy, or chiropractic care based on the documentation provided for review. Therefore, it is my medical opinion that the requested L2-S1 transforaminal lumbar interbody fusion with L1-L2 laminectomy with a 1-2 day inpatient length of stay is neither reasonable nor

necessary and would not be in accordance with the ODG. The previous adverse determinations should be upheld at this time.

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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**