DATE OF REVIEW: 08/10/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
360 Fusion L4-L5, Length of Stay 2-3 Days

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

REVIEW OUTCOME

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

☒Upheld (Agree)

☐Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:

- 360 Fusion L4-L5, Length of Stay 2-3 Days – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
An MRI of the lumbar spine with and without contrast, dated XXXX, performed at XX read by XXXX showed impression: 1. There was suggestion of disc extrusion and epidural fibrosis surrounding the disc herniation at L4/5. The appearance may be within the expected context if the claimant's surgery was within the last six weeks, if this is the case, then follow up imaging at a later date may be important. If the claimant's surgery was greater than six weeks ago, recurrent or residual disc extrusion with surrounding epidural fibrosis was likely. 2. There was less than 25% spinal canal stenosis at L3/4, a slight improvement from the comparison.

On XXXX performed a fluoroscopically guided left L4/5 selective nerve block.

On XXXX saw the claimant for Chronic Pain management. The claimant reported XXXX continued to experience an increase in low back soreness since participating in the program. XXXX rated current pain 8/10. Associated symptoms included pain and weakness in left LE. Exam findings showed limited ambulation. Neurological exam showed slow labored gait. Decreased sensation in left foot and leg. SLR positive on left. Exam of spine showed tenderness and decreased ROM. There was pain with extension and flexion. Pain with rotation to left and right. Decreased ROM, with left and right paraspinal spasms. Lumbar spine showed tenderness of iliolumbar region. Active ROM limited with pain. Flexion produced radiating pain into the left posterior thigh. Noted weakness with manual muscle testing 4+/5. Increased lower back pain with resisted knee flexion/extension. Left LE muscle atrophy is noted upon visual inspection. Diagnoses included intervertebral disc disorder. Recommended continued with chronic pain management program.

On XXXX, the claimant was seen by XXXX, for 80 hours Chronic Pain Management program. XXXX reported lower back symptoms consistent with constant pressure. Noted that XXXX upper extremities were strong however XXXX was unable to do most things secondary to onset of pain in lower back. No specific pain rating noted. Medications include XXXX. Claimant reported muscle aches and back pains and weakness and numbness. Exam findings showed limited ambulation. Neurological exam showed slow labored gait. Decreased sensation in left foot and leg. SLR positive on left. Exam of spine showed tenderness and decreased ROM. There was pain with extension and flexion. Pain with rotation to left and right. Decreased ROM, with left and right paraspinal spasms. Lumbar spine showed tenderness of iliolumbar region. Active ROM limited with pain. Flexion produced radiating pain into the left posterior thigh. Noted weakness with manual muscle testing 4+/5. Increased lower back pain with resisted knee flexion/extension. Left LE muscle atrophy is noted upon visual inspection. Diagnoses included intervertebral disc disorder. Continued pain management as ordered.

The claimant continued with Chronic Pain Management program from XXXX 3 visits. During this time symptoms remained essentially the same. XXXX continued with constant low back pain with radiation down left LE. Rated XXXX pain 8/10. Continued pain management as ordered.

On XXXX saw the claimant for CPM. XXXX rated XXXX lower back pain 7/10 on this date. Noted continued weakness in left LE. Medications include XXXX. Claimant reported muscle aches and back pains and weakness and numbness. Exam findings showed limited ambulation. Neurological exam showed slow labored gait. Decreased sensation in left foot and leg. SLR positive on left. Exam of spine showed tenderness and decreased ROM. There was pain with extension and flexion. Pain with rotation to left and right. Decreased ROM, with left and right paraspinal spasms. Lumbar spine showed tenderness of iliolumbar region. Active ROM limited with pain. Flexion produced radiating pain into the left posterior thigh. Noted weakness with manual muscle testing 4+/5. Increased lower back pain with resisted knee flexion/extension. Left LE muscle atrophy is noted upon visual inspection. Diagnoses included intervertebral disc disorder. Continued treatment as ordered.

A Lumbar Myelogram with post CT, dated XXXX, performed at XX read by XXXX showed impression: 1. L1/2 there was no evidence of disc herniation, thecal sac stenosis, or neural

foraminal encroachment. 2. L2/3 broad 1 mm disc bulge. 3. L3/4 broad 2 mm disc bulge. 4. L4/5 status post left hemilaminotomy. There was an 11 mm central and left paracentral disc protrusion/herniation which extrudes approximately 5 mm superior and inferior to the disc level. It caused severe thecal sac stenosis, severe left lateral recess narrowing, severe left neural foraminal narrowing, and moderate right neural foraminal narrowing with surrounding endplate osteophytes within each posterolateral area. There is definite left L5 nerve root impingement and probable left L4 nerve root impingement as well. The right L4 nerve root could also potentially be impinged upon due to the posterolateral endplate osteophytes on the right side. 5. L5/S1 1 mm posterior endplate osteophytes with no disc herniation or thecal sac stenosis. 6. 1mm calculus within the right kidney with no visible hydronephrosis. The kidneys are only partially included on the field of view of this exam.

X-ray lumbar spine, dated XXXX, read by XXXX showed impression: 1. Thoracolumbar dextroscoliosis. 2. Spondylosis change at L4/5 with loss of disc height. There were concavities along the ventral surface of the thecal sac at L3/4 and L4/5, suggesting underlying disc herniations at these levels.

CPM continued on XXXX, with XXXX. XXXX rated current pain 8/10 and reported increased weakness in left LE on this date. Exam findings remained the same. Continued pain management as ordered.

On XXXX saw the claimant for continued CPM. Claimant continued to have weakness and pain in the LE which limits XXXX daily activities. XXXX noted that XXXX pain ranged from 6/10 ad could include to 10/10. Current medications included XXXX. XXXX reported weakness and numbness in left lower leg. Past surgical history was positive for lumbar discectomy at L4 on XXXX. Reviewed prior radiological studies. Exam findings revealed limited ambulation with slow and labored gait. Neurological exam revealed decreased sensation of left foot and leg. SLR positive on left. XXXX was very frustrated with lack of improvement. Lumbar spine showed tenderness of the iliolumbar region. Pain with rotation to left and right on flexion. There were left paraspinal spasms bilaterally. XXXX had pain with motion with radiating pain produce on flexion down left posterior thigh. Diagnoses included intervertebral disc disorder. Continued with pain management

On XXXX saw the claimant for an orthopedic evaluation with complaints of lower back pain. Rated current pain 8/10. Reported symptoms of numbness/tingling, stiffness, weakness, limited ROM. Treatment had included PT, steroid injection, MRI, CT scan, and noted the claimant had multiple prior surgeries to the painful area. It was noted the neck and back were not examined. Reviewed prior MRI of lumbar spine performed on XXXX. Diagnoses included L4/5 herniated nucleus pulposus with radiculopathy. After 2 laminectomies, the claimant understood there would be extensive scar tissue that could limit the decompression that was needed though with fusion, could do a facetectomy and approach the herniated fragment from a different angle and likely have some success with surgery and give XXXX pain relief. Recommended quitting smoking and once XXXX quits, will proceed with surgery.

On XXXX saw the claimant for pre-surgical behavioral health evaluation. It was noted the claimant was injured while working for XXXX and sustained an injury to XXXX lower back and

left leg when XXXX. XXXX current pain was rated 8-9/10. The claimant had undergone a discectomy in XXXX, another discectomy in XXXX, and a spinal fusion in XXXX. The claimant XXXX. The claimant reported having lost about XXXX pounds in the XXXX months. The claimant reported a number of physical imitations including family activities. On review of educational history, the claimant completed high school. XXXX was currently off work. On exam the claimant was experiencing relatively high levels of depression and anxiety. FABQ revealed a high fear of physical activity. On PAIRS, score was 82 which was very elevated and suggested the claimant would continue to perceive XXXX as a disabled individual as long as there was any subjective discomfort. Without significant change in XXXX beliefs, this would be a poor prognostic sign for recovery of function. Scores in this range were normally associated with fairly poor outcome from traditional medical/surgical interventions and suggested the possibility of psychological factors contributing to a continued disability without essential changes in this mind set. The examiner also noted that the claimant was extremity sensitive to changes in XXXX bodily functions which may result in many somatic complaints and passive coping style may contribute to a lack of involvement in self-care and preference for playing the role of victim. Diagnoses included somatic symptom disorder with predominant pain, adjustment disorder with mixed anxiety and depressed mood, moderate psychological stressors with ongoing effects of physical injury, physical limitations, uncertain of vocational outlook. The claimant did not exhibit any psychological or behavioral risk factors and XXXX would fall in the "fair prognosis" category, thus the claimant was clear for surgery.

On XXXX saw the claimant for follow up. Noted XXXX. Medications include XXXX. Claimant continued to complain of weakness and numbness to left lower leg. Exam of spine and lumbar spine showed tenderness in back and decreased ROM in lower back with pain on flexion/extension. Flexion produced radiating pain into the left posterior thigh. Neurological exam showed slow and labored gait. Sensation was decreased in left foot and leg. SLR positive on left. Noted left and right paraspinal spasm. XXXX has recommended surgery and requested expedited approval for surgery. Claimant will need psychological eval. for clearance for surgery. Diagnoses included displacement of lumbar intervertebral disc without myelopathy. Allowed to work with restrictions per DWC73.

On XXXX requested pre-authorization for 360 fusion L4/5 and revision of laminectomy.

UDS, dated XXXX, revealed normal ranges of XXXX.

On XXXX saw the claimant for follow up on low back pain. XXXX continued with pain rating 8/10 with symptoms of numbness/tingling, pain with motion, weakness with motion. Neck and back exams were not performed. Diagnoses included L4/5 herniated nucleus pulposus with radiculopathy. As discussed on previous visit recommended revision laminectomy at L4/5 and an anterior posterior fusion. According to UDS, the claimant's nicotine test was within in good range. Will proceed ahead with approval for an L4/5 anterior posterior fusion with laminectomy.

On XXXX requested pre-authorization for 360 fusion L4/5 and revision laminectomy.

On XXXX, the request of 360 fusion L4/5 revision laminectomy with length of hospital stay of 2-3 days was denied by insurance. The review noted that there was limited documentation of

objective findings in the most recent medical report to fully meet criteria and necessitate the requested surgery. There were no clear documented measurable objective findings of failure from nonoperative treatment. During the peer review, the provider stated there was no instability and there was disc height vacuum at that level. A redo MLD was suggested and a possibility of CT was discussed to see if there was calcification as it was unclear if the pain was radicular or discogenic. After discussion, there were not enough physical exam findings to warrant the requested surgery.

On XXXX requested reconsideration for 360 fusion L4/5 with revision laminectomy.

On XXXX, the appeal for 360 fusion L4/5, revision laminectomy with length of stay 2-3 days was denied by insurance. Discussion with XXXX, designee, stated the claimant had a previous surgery and it was felt that there would be iatrogenic instability. This reviewer noted that another decompression in a patient of this age would be preferable. The designee though that any relief from decompression would be short lived, given the disc height loss and vacuum disc. It was also stated that the claimant was a smoker and this is a known contraindication to a spinal fusion.

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

The claimant is a XXXX and has undergone a lumbar discectomy at L4 on XXXX. The claimant had a lumbar myelogram/CT performed on XXXX with the radiologist reporting the following at L4-5: L4/5 status post left hemilaminotomy. There was an 11 mm central and left paracentral disc protrusion/herniation which extrudes approximately 5 mm superior and inferior to the disc level. It caused severe thecal sac stenosis, severe left lateral recess narrowing, severe left neural foraminal narrowing, and moderate right neural foraminal narrowing with surrounding endplate osteophytes within each posterolateral area. There is definite left L5 nerve root impingement and probable left L4 nerve root impingement as well. The right L4 nerve root could also potentially be impinged upon due to the posterolateral endplate osteophytes on the right side. The claimant was then evaluated by a surgeon who recommended the L4-5 revision laminectomy with an anterior and posterior fusion. The surgeon's office visit note indicated that a physical exam was not performed of the neck or the back. The claimant was advised to discontinue smoking and when that was accomplished, the surgery would be ordered. Lab work on XXXX revealed that nicotine levels were negative. The claimant had a presurgical psychological evaluation that noted the claimant did not exhibit any psychological or behavioral risk factors and XXXX would fall in the "fair prognosis" category, thus the claimant was clear for surgery. However, review of the report revealed that the claimant was experiencing relatively high levels of depression and anxiety. FABQ revealed a high fear of physical activity. On PAIRS, score was 82 which was very elevated and suggested the claimant would continue to perceive XXXX as a disabled individual as long as there was any subjective discomfort. Without significant change in XXXX beliefs, this would be a poor prognostic sign for recovery of function. Scores in this range were normally associated with fairly poor outcome from traditional medical/surgical interventions and suggested the possibility of psychological factors contributing to a continued disability without essential changes in this mind set. The examiner also noted that the claimant was extremity sensitive to changes in XXXX bodily functions which

may result in many somatic complaints and passive coping style may contribute to a lack of involvement in self-care and preference for playing the role of victim. This examiner's report also indicated that the claimant had undergone a spinal fusion in XXXX though that was not documented elsewhere in the other medical records.

During case discussions, the treating surgeon has reported that there is no spondylolisthesis or fracture of the lumbar spine and noted that this would be the claimant's third discectomy. While the ODG does note that fusion may be an option at the time of the third discectomy, the discectomy/laminectomy would need to meet ODG criteria. In this case, there are no clinical exam findings by the treating surgeon to correlate with the lumbar myelogram/CT findings. Therefore, as medical necessity is not met for the discectomy/laminectomy at L4-5, the medical necessity for a fusion at the time of a third discectomy is not medically necessary. Furthermore, with literature identifying that risks exceeds benefit for risks exceeding benefit particularly in workers' compensation patients for disc herniation, and based on the FABQ and PAIRS psychological testing results that suggested the claimant would continue to perceive XXXX as a disabled individual as long as there was any subjective discomfort, medical necessity for the anterior/fusion is not met.

In summary, medical necessity is not established for the lumbar discectomy/laminectomy or the anterior and posterior fusion at L4-5 and therefore, there is no medical necessity for a 2 to 3 day length of hospital stay.

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

☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**