Notice of Independent Review Decision

Date notice sent to all parties: 12/16/2017

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of transforaminal decompression and instrumented lumbar interbody fusion L5-S1.

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

The reviewer is a Medical Doctor who is 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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of transforaminal decompression and instrumented lumbar interbody fusion L5-S1.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a XXXX XXXX XXXXX who sustained an industrial injury on XXX. The mechanism of injury was described as XXXX. XXXX underwent lumbar microdiscectomy, laminectomy, foraminotomy, and partial facectomy on the left at L5/S1 on XXX. The 4/8/16 lumbar spine MRI impression documented a 5-6 mm diffuse disc herniation at L5/S1 and a superimposed broad-based left lateral recess disc herniation. There was moderate to severe left neuroforaminal stenosis with impingement of the left L5 exiting nerve root and moderate right foraminal stenosis. The XXXX spine surgeon report cited continued low back and left leg pain. XXXX had undergone a lumbar epidural steroid injection with only 2 days of relief. XXXX continued to modify XXXX activities and perform home exercises. Lumbosacral exam documented positive left straight leg raise tests. Lower extremity neurologic exam documented 5/5 strength, decreased left S1 sensation, and diminished left Achilles reflex. XXXX had progression of XXXX disc herniation at L5/S1. XXXX had persistent intractable symptoms despite conservative care. XXXX was a candidate for complete facectomy at L5/S1 with

transforaminal decompression and instrumented fusion through a transforaminal lumbar interbody fusion (TLIF) approach. XXXX would continue to work as symptoms allow. The XXXX psychological evaluation report indicated that the claimant was an acceptable candidate psychologically for spine surgery. The XXXX spine surgeon progress report cited continued low back pain radiating into the lateral and posterolateral left lower extremity in an L5/S1 distribution. XXXX continued to work regular duty despite XXXX persistent symptoms. Lumbosacral exam documented positive left straight leg raise tests. Lower extremity neurologic exam documented 5/5 strength, decreased left S1 sensation, and diminished left Achilles reflex. XXXX had persistent symptoms and desired definitive treatment that would include a revision decompression and fusion. The treatment plan recommended complete facectomy at L5/S1 with transforaminal decompression and instrumented fusion through a transforaminal lumbar interbody fusion (TLIF) approach. The XXXX spine surgeon progress report cited continued significant low back and left leg pain. Lumbosacral exam documented positive left straight leg raise tests. Lower extremity neurologic exam documented 5/5 strength, decreased left S1 sensation, and diminished left Achilles reflex. XXXX had undergone psychological exam and was cleared for surgery. The diagnosis included recurrent L5/S1 disc herniation, disc space collapse, and history of previous discectomy. XXXX had continued significant low back pain and had undergone multiple forms of conservative therapy and psychological evaluation and was cleared for surgery. The treatment plan recommended L5/S1 transforaminal decompression and instrumented fusion through a TLIF approach. The XXXX peer review determination letter indicated that the request for outpatient surgery: transforaminal decompression and instrumented lumbar interbody fusion at L5/S1 was not medically necessary. The rationale stated that the claimant's prior imaging was outdated and more than a XXXX, there was no current indication of any significant spondylolisthesis or motion segment instability, and XXXX had only undergone one prior lumbar decompression at L5/S1. The XXXX peer review determination indicated that the request for outpatient surgery: transforaminal decompression and instrumented lumbar interbody fusion at L5/S1 was not medically necessary. The rationale stated that the imaging was outdated, there was no evidence of multiple decompression procedures, and there was no associated severe spondylolisthesis or motion segment instability to support proceeding with a lumbar spinal fusion. Additionally it was noted that there was no documentation of any recent non-operative measures, such as physical therapy. The XXXX treating physician report cited complaints of worsening low back and radicular pain. XXXX underwent a lumbar epidural steroid injection on XXX, and had limited improvement with physical therapy from XXX through XXXX with transition to a home exercise program. Lumbar spine exam documented moderate left paraspinal tenderness and hypertonicity, positive left straight leg raise tests, positive left Kemp's test, and positive Patrick's and Yeoman's tests. Range of motion was restricted. Left calf circumference was 36.0 cm and right calf circumference was 37.5 cm. The left Achilles reflex was hypo-reflexive. The diagnosis included lumbar radiculopathy and lumbar intervertebral disc displacement. The treatment plan recommended surgery as the epidural steroid injection in the lumbar spine gave XXXX some temporary pain relief for 1-2 weeks, and all other conservative efforts had failed. XXXX had MRIs on XXX, XXX, XXX, and XXX that all revealed similar findings of the disc herniation at L5/S1 with impingement on the exiting nerve root. Appeal of the surgery was requested.

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

The Official Disability Guidelines recommend criteria for lumbar decompression that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. The Official Disability Guidelines do not recommend lumbar fusion for patients

with degenerative disc disease, disc herniation, spinal stenosis without degenerative spondylolisthesis or instability, or non-specific low back pain. Fusion may be supported for segmental instability (objectively demonstrable) including excessive motion, as in isthmic or degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating spinal instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, spine fusion to be performed at 1 or 2 levels, psychosocial screening with confounding issues addressed, and smoking cessation for at least 6 weeks prior to surgery and during the period of fusion healing.

This claimant presents with persistent significant low back pain radiating into the left lower extremity in an L5/S1 dermatomal distribution. Functional difficulty is noted in activities of daily living and work ability. XXXX is working but with persistent symptoms. Clinical exam findings have documented sensory deficits and reflex changes that correlate with reasonably recent imaging evidence on XXX of disc herniation at L5/S1 with lateral recess stenosis and left L5 nerve root impingement. Detailed evidence of long term reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. XXXX is status post lumbar microdiscectomy, laminectomy, foraminotomy and partial facectomy on the left at L5/S1 in XXXX. There is no radiographic evidence of spondylolisthesis or spinal segmental instability on flexion and extension x-rays. The previous denial and rationale was reviewed in detail.

However, the spine surgeon has documented the need for wide decompression with complete facectomy that would result in temporary intraoperative instability and necessitate fusion. There is documentation of psychological clearance for surgery. XXXX is a never smoker. Guideline criteria have been met for the requested decompression and fusion procedure. Therefore, this request for transforaminal decompression and instrumented lumbar interbody fusion L5/S1 is medically necessary.

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)**