AccuReview

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June 18, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
L4-S1 PLIS, PLF w/XX, XX, XX, XX, XX, bone marrow aspiration, XX and 3-day inpatient stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Neurosurgery with over 15 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]:
XXXX: Office Visit dictated by XXXX. Claimant returns today after PT reporting it did not help, nor did taking high-dose scheduled XXXX. XXXX has also undergone further extensive conservative management with XXXX including a lumbar ESI and radiofrequency ablation. None of these modalities have helped significantly with XXXX current s/s; mainly include low back pain, located posteriorly, sharp in nature, and at its worst is a 10/10. XXXX has pain and paresthesias that radiate into XXXX proximal bilateral lower extremities. These symptoms continue to progressively worsen and are adversely affecting XXXX normal activities of daily living and decreasing XXXX quality of life. Current Medications: XXXX. PE: WNL. DX: S30.0XXD Contusion of lower back and pelvis, subsequent encounter, S32.2XXD Fracture of coccyx, subsequent encounter for fracture with routine healing, M51.36 Other Intervertebral disc degeneration, lumbar region. Plan: The claimant has intractable axial low back pain and has failed extensive conservative management and XXXX symptoms are adversely affecting XXXX normal activities of daily living. There are no further options for conservative measures and unfortunately, XXXX is likely suffering from micro instability which would then necessitate a lumbar fusion surgery. To investigate this hypothesis. Ordered x-rays to assess gross instability and a lumbar discogram at the L4-L5 and L5-S1 levels with a good control level to assess for any micro instability. RTC after exams.

XXXX: Consultation dictated by XXXX. CC: LBP with radiation down right leg. Pain described as sharp, shooting, numbing, burning, dull, stabbing, with associated muscle spasms. Pain 6/10, avg pain 6-7/10, with pain medications 4/10 and without pain medication 6-7/10. Pain aggravated with walking, crouching, kneeling, bending, twisting, moving, standing, sitting, various activity. Alleviated by sitting. Active medications: XXXX. Denies ETOH, drug use or smoking history. PE: lumbar spine: tenderness, but no palpable trigger points in the para-vertebral areas. There is pain on pressure over the lumbar facet joints bilaterally and tenderness to palpation of the sacrum and coccyx. Extension limited due to pain, left rotation limited due to pain, right rotation limited due to pain, left lateral bending due to pain and right lateral bending limited due to pain. DX: strain of muscle, fascia and tendon of lower back S39.012A, Fracture of coccyx, initial encounter for closed S32.2XXA. Assessment and Plan: medical management to continue with present medication including: XXXX.

XXXX: Office Visit dictated by XXXX. CC: LBP with radiation down right leg. Claimant reported increase in XXXX did not help in XXXX radicular symptoms and will refer to chronic pain therapy. Pain reported 8/10 and occurs constantly 76-100% of the day. DX: Strain of muscle, fascia and tendon of lower back, contusion of lower back and pelvis, initial encounter, long term use of opiates, encounter for therapeutic drug level monitoring. Assessment/Plan: continue with present medications including XXXX.

XXXX: Diagnostic Narrative dictated by XXXX. The claimant appears to be in need of specialized support and skills training, and this treatment request is therefore judged to both medically necessary and related to the altered medical and psychological circumstances brought about by XXXX work-related injury.

XXXX: Office Visit dictated by XXXX. CC: LBP with radiation down right leg. Requesting pain and medication management. Based on evaluation, XXXX is suitable candidate for the procedure. Discussed discogram with claimant and all questions were answered. XXXX would like to proceed as XXXX is motivated to have surgery if that is what is necessary to decrease XXXX narcotics, return him back to functional ADLs and enable gainful employment. Will request authorization through work comp. XXXX continues XXXX for pain with good control. XXXX purchased and inversion table, which helps reduce XXXX pain very short term. XXXX failed land-based PT due to increased pain, will refer to aqua therapy to reduce pain and continue chronic pain therapy. Functional Rehabilitation: PT, TENS unit. PE: unchanged. DX: Strain of muscle, fascia and tendon of lower back, contusion of lower back and pelvis, initial encounter, long term use of opiates, encounter for therapeutic drug level monitoring. Assessment/Plan: continue current medication management, provocative lumbar discogram at L4-L5, L5-S1 with control level, start aqua therapy.

XXXX: Lumbar Spine CT Following Discography dictated by XXXX. Impression: 1. Grade III disc at L4-5 and Grade IV disc at L5-S1, 2. Grade 0-1 disc at L3-4 where contrast protrudes slightly into the annulus fibers on the right but is mostly confined to the nucleus pulposus.

XXXX: Medical Evaluation dictated by XXXX. The claimant is a XXXX, sustained a work-related injury on XXXX when XXXX. XXXX experienced low back and buttocks pain immediately. DX: sacrococcygeal contusion, lumbar contusion, chronic pain syndrome. The treatment rendered, for the most part, has been reasonable, necessary and appropriate. This would include PT, oral medications, activity modification, facet injections, trigger point injections and aqua therapy, as well as psychotherapy. Recommend proceeding with surgical intervention. XXXX does not seem to be responding to current treatment, as XXXX symptoms have worsened since injection. Recommend aqua therapy, followed by PT and a work hardening program, wean off narcotics and restrict to XXXX for pain, if necessary. Also recommend psychological treatment to assist with coping mechanisms, if indicated. There are associated comorbidities, including facet degeneration, as well as lumbar disc degeneration. These certainly could impact the current injury, in that the injury could have initiated or exacerbated any pre-existing symptoms; however, should have long resolved. The claimant should return to work perhaps full duty, if not modified duty after the completion of work conditioning program and functional capacity evaluation. XXXX has not reached MMI, anticipated on XXXX. Surgical intervention is not recommended at this time.

XXXX: Completion of Psychological Evaluation dictated by XXXX. The claimant presented with an established history of psychological resiliency and notable ego strengths, ruling out issues of marked psychogenic overlay or significant secondary gain, and is therefore cleared to have the procedure.

XXXX: Pre-Authorization dictated by XXXX. The clinical information provided does not establish the medical necessity of this request. The surgical request is not supported by ODG. The CT dated XXXX shows disc pathology at L4-5 and L5-S1. There is report of back pain and pain into legs, right more than left. The discogram dated XXXX showed concordant pain at L4-5 and L5-S1. However, there is no pain at L3-4, discograms have fallen out of favor and do not predict success for surgery per the guidelines. Additionally, there is no instability demonstrated. Therefore, there is no indication for fusion surgery and medical necessity is not established.

XXXX: Lumbar Spine, Flexion and Extension Lateral Views dictated by XXXX. Impression: No spondylolisthesis or motion-induced segmental instability in the lumbar spine.

XXXX: MRI of the Lumbar Spine without Contrast dictated by XXXX. Impression: Mild spondylosis at L4-5 and L5-S1 levels as described. There is no significant central or foraminal stenosis. No definite focal nerve root compression is identified.

XXXX: Office Visit dictated by XXXX. CC: LBP. DX: M51.36-722.52 Other intervertebral disc degeneration, lumbar region.

XXXX: Request for Surgery authorization dictated by XXXX. Requested 22633, 22634, 22842, 22853 x2, 20930, 20936, 20939, 63047, 63048, 61783 L4-S1 PLIS, PLF w/Medtronic instruments, XX, XX, XX, XX, XX, XX and XX and 3-day inpatient stay.

XXXX: UR performed by XXXX. Reason for denial: According to the documentation, imaging studies on this injured worker do not show the presence of any spondylolisthesis or instability. This is not a third requested lumbar spine procedure. Accordingly, there is no indication for any stabilization procedure. This request is not established as medically necessary.

XXXX: UR performed by XXXX. Reason for denial: The clinical information provided does not establish the medical necessity of this request. According to the ODG, the injured worker did not meet criteria for proceeding with the operative procedure. Despite complaints of low back pain with radiation down the lower extremity, there was no evidence of nerve compression or instability identified on imaging studies. Guidelines indicate that stabilizing procedures are only indicated for patients who have ongoing symptoms with corroborating physical exam findings and imaging after failure of nonoperative treatment measures. Without evidence of an unstable fracture, dislocation or acute spinal cord injury and no evidence that the injured worker had a spinal infection or indication of spinal listhesis, the surgery is not indicated. Moreover, the request for amniotic membrane allograft is considered investigational. The available documentation does not indicate exceptional factors that would support the requested services as an outlier to the guidelines. Therefore, the request for L4-S1 PLIS, PLF w/ XX, XX, XX, XX, XX, XX, XX and XX is not established as medically necessary. Regarding the request for inpatient stay, the ODG, Work Loss Data Institute, 2048; Low Back – Lumbar and Thoracic Chapter: Hospital Length of Stay. As the surgery is not supported, the request for 3-day inpatient stay is not established.

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

The previous adverse determination is upheld and agreed with. The claimant had a work injury in which XXXX. There is no documentation of spondylolisthesis, spondylolysis, compression fracture or ligamentous instability noted on the Lumbar X-rays, CT or MRI. The claimant does not have any rationale for a two-level lumbar fusion and pedicle screw fixation. The use of diskogram is controversial and the benefit of fusion without spondylolisthesis or instability is poor. After reviewing the medical records and documentation provided, medical necessity cannot be established for the claimant to need the requested services. The patient's history and exam are more concerning for Fibromyalgia or chronic muscle sprain which also are not helped by lumbar fusion. Surgery is not supported for this claimant at this time. Therefore, the request for L4-S1 PLIS, PLF w/XX, XX, XX, XX, XX, XX, XX and XX and 3-day inpatient stay is denied and non-certified.

Per ODG: XX

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)**