Magnolia Reviews of Texas, LLC
PO Box 348
Melissa, TX 75454
972-837-1209 Phone 972-692-6837 Fax
Email: Magnoliareviews@hotmail.com

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lateral 360 lumbar fusion L4-5, revision L5-S1, iliac crest graft, XX, XX and DME: LSO brace with 3 day inpatient stay

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

MD, Board Certified Neurosurgery

REVIEW OUTCOME:

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

[X] 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]:

The patient is a XXXX-year-old-individual who sustained an injury to the low back on XXXX. The patient was XXXX. As the patient was XXXX, the patient felt pain in the back. The patient weighs XXXX pounds and had a body mass index (BMI) of XXXX. Past medical history was significant for hypertension and a prior lumbar fusion at L5/S1. Radiographs of the lumbar spine dated XXXX note a loss of disc height at L4/5. At L5/S1 there is both anterior and posterior fusion with no evidence of hardware failure. An MRI of the lumbar spine dated XXXX notes disc desiccation at L4/5. There is mild 2-3mm disc bulge/protrusion within the left neural foramen. Mild bilateral facet hypertrophy is seen. There is mild to moderate left foraminal encroachment. The thecal sac at this level measures 6.5mm AP centrally. At L5/S1 there are postsurgical changes. No obvious spinal canal stenosis or foraminal encroachment is seen. Question right hemilaminectomy changes. The submitted clinical records indicate the patient has received 6 sessions of physical therapy that were of no benefit. The patient underwent an LESI at L4/5 that the patient reports made XXXX pain worse. Serial examinations are basically unremarkable and non-diagnostic. The patient was seen in follow-up on XXXX by XXXX. At this time it is reported that there is decreased sensation in the left lower extremity in the L3 and L4 dermatomes. The patient was seen in follow-up by neurosurgery on XXXX and is reported to have weakness in the right quadriceps and TA and a decreased L4 reflex on the right. On XXXX an initial review was performed by XXXX. "This patient sustained a XXXX dated XXXX and reports worsening low back pain that radiates to the knee, thigh, and foot bilaterally. An exam revealed a normal range of motion and the motor strength was 4.5/5 of the right quadriceps and tibialis anterior. Reflexes at L4 was depressed. Computed tomography (CT) of the lumbar spine dated XXXX documented that there were stable postoperative changes with mild multilevel spondylosis. X-ray of the lumbar spine dated XXXX documented that there was posterior and anterior fusion and intervertebral prosthesis at L5-S1. The vertebral body height was maintained. No pathologic motion was evident with flexion and extension. The paravertebral tissues were unremarkable. The patient has tried therapy, medications, and injection, however, recent and reasonable comprehensive non-operative treatments, psychosocial screening, and segmental instability have not been documented, as required by ODG. Therefore medical necessity has not been established at this time and the request is non-authorized". The appeal request was reviewed by XXXX on XXXX. "The request was previously noncertified on XXXX, due to lack of pre-surgical psychological screening and lack of medical necessity of the procedure. No additional documentation was submitted. The request remains noncertified. The diagnostic imaging, x-rays and CT, document no

evidence of significant spinal instability which would support the medical necessity of the requested surgery. There is no substantial documentation of neurological deficit; there are mild, soft findings on examination. Without objective evidence of significant segmental instability, in accordance with the guideline treatment recommendations, as well as pre-surgical psychological screening prior to surgery, the surgical request is not medically supported. Therefore, without documentation supporting medical necessity of the surgery, inpatient hospital stay and postoperative brace would not be warranted. The case was discussed with XXXX, who stated there is a herniated disc at L4-L5. No evidence of instability was provided to support a fusion. There was no clear indication for revision of the previous fusion at L5-S1. The claimant is XXXX and weighs XXXX. The claimant has XXXX that needs to be addressed prior to any major spine surgery. The request does not meet guideline criteria. The reconsideration review of a previously noncertified request for lateral 360 lumbar fusion of L4-L5, revision of L5-S1, iliac crest graft, XX, XX and durable medical equipment with an LSO brace, with a three-day inpatient stay".

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

The request for lateral 360 lumbar fusion L4-5, revision L5-S1, and iliac crest graft, XX, XX and DME: LSO brace with 3 day inpatient stay is not supported as medically necessary and the prior determinations are upheld. The submitted clinical records indicate the patient sustained an injury to XXXX low back while XXXX. The patient has a prior history of L5/S1 fusion in XXXX. The serial records indicate the patient has had limited conservative management that consisted of approximately 6 sessions of physical therapy and an LESI. The serial records essentially document normal examinations with no hard correlative findings on examination until XXXX. On this date the patient is reported to have left lower extremity sensory loss. Three days later the patient was seen in follow-up by neurosurgery and reported to right lower extremity motor weakness and a decreased L4 reflex. The lack of continuity between examinations is concerning and fails to establish the presence of a pain generator. The patient is XXXX without consistent findings on examination making any type of lumbar surgery an extreme risk. Further the patient would require a preoperative psychiatric evaluation as there is no instability noted on flexion and extension views. The available records do not indicate the patient was ever referred for evaluation after initial denial. Based on the totality of the presented information the patient does not meet evidenced based guidelines for the requested surgical procedure and the prior denial are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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

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

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