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Notice of Independent Review Decision

March 10, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Anterior Lumbar Interbody Fusion L2-3 L3-4, Lateral Approach with Posterior Lumbar Decompression (To Include Facetectomies which may predispose the patient to Iatrogenic Instability), Posteriolateral Fusion and pedicle screw Instrumentation at L2-3 L3-4, 2 day inpatient stay 2258 22851 22612 22614 63047 63048 22840 20902x2 77002x2 38220x2 95937x2

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This reviewer is a Board Certified Neurological Surgeon with over 16 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]:

The claimant is male who had a work related injury on xx/xx/xx when he was shoveling steel into a dumpster.

02/25/2014: Office Visit. **Subjective:** HPI: Patient reports sharp pain for over 1 year, continuous, occurring at night. Prior episodes of similar lumbar spine pain, the lumbar spine pain was preceded by lifting carrying, or bending the lumbar spine pain was preceded by injury. Difficulty walking, claudication. Medications: Lunesta 3 mg tablet, Oxycodone 30 mg tablet, diazeparn 10 mg tablet, Doxepin 25 mg capsule. Reports back problems, joint pain, muscle stiffness, weakness, muscle cramps, restricted motion. **Physical Exam:** Lumbar pain radiate down to leg, unsteady gait and weakness of back and leg. **Assessment:** Lumbar

Radiculitis, chronic. Degeneration Lumbar Disc(s), chronic. Low back pain, chronic. Muscle spasm, chronic. **Plan:** Office/outpatient visit est, special report or forms, oxycodone 30 mg tab-1 tab every 4 hours as needed. Lunesta 3 mg tablet-1 tab by mouth at bedtime. Diazepam 10 mg tab-1 tab by mouth twice daily. Chantix 1 mg tab-1 tab by mouth twice daily.

03/10/2014: Office Visit. **HPI:** Patient returns for follow up with no improvement in his previous symptomatology which he described as sharp and stabbing low back pain with radiation into the left lower extremity along the anterolateral thigh and calf, and constantly into the dorsum of the left foot with associated numbness and tingling in a similar distribution. Pain level 9/10. He is a less than one pack per day smoker. Negative ETOH. **Examination:** Patient is 5'10, weight 220 pounds with a BMI of 31.6. Lumbar ROM was decreased in forward flexion secondary to pain. Motor exam reveals 3/5 strength of the tibialis anterior, extensor halluces longus and quadriceps femoris muscles on the left, otherwise 5/5 throughout. Deep tendon reflexes were +1 in the knee jerk on the left, otherwise +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Gait was antalgic. The patient had marked difficulty with heel walk secondary to weakness and difficulty with toe walk secondary to pain. Tandem walk was also difficult secondary to pain. Straight leg raise was positive on the left at 20 degrees and positive on the right at 45 degrees. Sensory exam reveals a hypoesthetic region over the L4 and L5 distributions on the left to pin prick and light touch, otherwise intact. **Impression:** 1. Lumbar mechanical/discogenic pain syndrome at L3-4 and L4-5 2. Recurrent herniated nucleus pulpous at L3-4 and L4-5 3. Recurrent lumbar radiculopathy 4. Lumbago, status post lumbar decompression at L4-5 and questionably at L3-4. **Recommendations:** 1. CT myelogram to further evaluate the central canal and neural foramina and this is for surgical planning. 2. In the interim I would also like the patient to perform supervised physical therapy. 3. Lumbar spine series in the standing position including flexion, extension and oblique views.

05/12/2014: Office Visit. **Subjective:** Last RX filled for only one week as oxycodone lr30 number 56 for one week. We are decreasing meds from oxy 240 to 180 as an attempt to decrease meds. Pt surgical intervention still stalled by carrier, PCAG reviewed and discussed, will fill oxycodone IR 30 number 180. Prior RX was RX number N528130 at 9404338056. **Assessment:** Reported back problems, muscle cramps, restricted motion, joint pain, muscle stiffness, joint stiffness, deformities, weakness. Reported difficulty walking claudication.

06/02/2014: Office Visit. **Subjective:** Back pain, lower region. Reported sharp pain for more than 1 year. Reports difficulty walking, claudication. Reports back problems, muscle cramps, restricted motion, joint pain, muscle stiffness, joint stiffness, deformities, weakness. **Physical Exam:** Palpation of the temporal and masseter muscles reveals normal strength of muscle contraction. Lumbar pain radiate down to leg, unsteady gait and weakness of back and leg. **Assessment:** Lumbar Radiculitis 7244 chronic, Degeneration Lumbar Disc(s) 72252 chronic, Low back pain 7242 chronic, Muscle spasm 72885 chronic **Plan:** Oxycodone 30 mg tablet 1 tab by mouth every 3 hours. #180.

06/16/2014: Office visit. **HPI:** is seen in follow up. He was last seen on March 10, 2014 at which time it was recommended he obtain a CT myelogram of the lumbar spine. The patient now returns in follow up having completed said study with no improvement in his previous symptomatology which was described as sharp and stabbing low back pain with radiation into the left lower extremity along the anterolateral thigh and calf, and constantly into the dorsum of the left foot with associated numbness and tingling in a similar distribution. He currently describes his pain level as a 6/10 on a visual analog scale with worsening symptomatology following prolonged sitting, standing, coughing, sneezing or Valsalva maneuver. **Examination:** Lumbar ROM was decreased in forward flexion secondary to pain. Motor exam reveals 3/5 strength of the iliopsoas, quadriceps femoris and extensor halluces longus muscles on the left, otherwise 5/5 throughout. Deep tendon reflexes were +1 of the knee jerk on the left, otherwise +2 throughout and symmetrical. Plantar responses were flexor bilaterally. Gait was antalgic. The patient had difficulty with heel walk secondary to pain and weakness, and difficulty with toe walk secondary to pain. Tandem walk was also difficult secondary to pain. Straight leg raise was positive on the left at 20 degrees and on the right at 45 degrees. Sensory exam reveals a hypoesthetic region over the L3, L4 and L5 distributions on the left to pin prick and light touch, otherwise intact. Coordination was intact in finger to nose exam and rapid alternating movements. Previous lumbar incision approximately 4 inches in length in the midline is well healed. **Radiographic Exam:** I reviewed a CT myelogram of the lumbar spine on film dated May 27, 2014. I cannot appreciate any obvious laminectomy defects at any of the visualized levels. There is straightening of the lumbar lordosis, likely secondary to muscle spasms. There is a large disc herniation at L2-3 paracentrally and to the left approximately 6-7 mm with severe lateral recess stenosis on the left and mild foraminal stenosis on the left. Facet joint hypertrophy bilaterally, left side greater than right contributing to said stenosis in addition to central canal stenosis with an AP diameter down to approximately 7 mm. There is decreased disc height, disc desiccation and internal disc disruption noted. L3-4 demonstrates a disc herniation paracentrally and toward the left approximately 4-5 mm with left sided foraminal and lateral recess stenosis. Facet and ligamentum flavum hypertrophy contributing to said stenosis in addition to central canal stenosis with an AP diameter down to approximately 7 mm with decreased disc height, disc desiccation and internal disc disruption noted. Incidental finding of an L4-5 annular protrusion paracentrally and to the left, however, without significant central canal and neuroforaminal stenosis noted at this level. **Impression:** 1. Recurrent lumbar radiculopathy 2. Recurrent herniated nucleus pulposus at L2-3 and L3-4 3. Lumbar mechanical/discogenic pain syndrome 4. Lumbago, status post lumbar decompression at L2-3 on the left in 2008. **Recommendations:** Due to failure of conservative medical therapy including physical therapy and epidural steroid therapy, pain duration greater than six months, current neurologic status with evidence of the radiographic findings as noted above, at this time I recommend: 1. Anterior lumbar interbody fusion at L2-3 and L3-4, lateral approach with posterior lumbar decompression, posteriolateral fusion and pedicle screw instrumentation at L2-3 and L3-4.

01/07/2015: UR **Rational for Denial:** The patient was recommended for I/P Anterior Lumbar Interbody Fusion L2-3 L3-4, Lateral Approach with Posterior Lumbar Decompression (To include Bilateral Facetectomies which may predispose the patient to Iatrogenic Instability), Posterolateral fusion and pedicle screw instrumentation at L2-3 L3-4, 2 day inpatient stay 2258 22851 22612 22614 63047 63048 22840 20902x2 77002x2 38220x2 95937x2. The patient developed complaints of low back pain while shoveling steel into a dumpster. The patient had prior physical therapy in 2009. It appears the patient was recommended for injections however this does not appear to have ever been approved through insurance. The last imaging study for the patient the last MRI for the patient was from 02/12 which showed degenerative disc disease at L2-3 and L3-4 with evidence of borderline canal stenosis at both levels. Radiographs of the lumbar spine from 02/06/13 noted mild degenerative disc disease at L3-4. The patient was seen for a pre-operative psychological evaluation on 10/07/14 which found no contraindications from a psychological perspective regarding surgery. The clinical record on 12/08/14 noted continuing complaints of low back pain radiating to the left lower extremity in the anterolateral thigh and calf with associated numbness in the left foot. Physical examination noted mild to moderate weakness of the left iliopsoas, quadriceps femoris, and extensor halluces longus. The patient had antalgic gait with difficulty heel and toe walking to the left side. Straight leg raise was positive to the left and there was a positive tandem walk. Sensory evaluation noted hypoesthesia in L3 through L5 distribution. Although the patient presents with neurological findings on the most recent physical examination there are no updated MRI studies available for review reviewing substantial pathology at L at either L3-4 or L4-5 that would support the proposed procedures. The patient does not have any further diagnostic evidence of lumbar radiculopathy through EMG. There is also no discussion regarding any recent conservative treatment with the last physical therapy documentation noted from 2009. Given the absence of updated imaging studies and clinical documentation of recent conservative treatment this reviewer would not recommend certification for the proposed procedures at this time. As the surgical request for this patient is not medically indicated, there would be no requirement for the requested inpatient stay.

02/09/2015: UR **Rationale for Denial:** The patient is a male who had work related injuries in xx/xx/xx while he was shoveling steel into a dumpster. He was initially treated conservatively with physical therapy and epidural steroid injections with little success. He underwent lumbar decompression at L4-5 in 2008. Post-operatively he went to physical examination with very little success. Clinical note dated 12/08/14 physical examination indicated lumbar spine ROM was decreased in forward flexion secondary to pain. Motor exam revealed 3/5 strength of the iliopsoas, quadriceps femoris, and EHL muscles on the left, otherwise 5.5 throughout. Deep tendon reflexes were +1 of the knee jerk on the left, otherwise 2+ throughout and symmetrical. Plantar responses were flex were bilaterally. Gait was antalgic. He had difficulty with heel and toe and tandem walk secondary to pain and weakness. Straight leg raise was positive on the left at 20 degrees and on the right at 45. Sensory exam revealed hypoesthetic region over the L3, L4 and L5 distribution son the left to pin prick and light touch, otherwise intact. X-ray examination of the lumbar spine dated 2/6/13 with flexion/extension lateral views

showed mild degenerative disc disease at L3-4. These findings were consistent with borderline spinal canal stenosis. L4-5 2-3mm broad based soft tissue disc protrusion below the level of the exiting nerve roots. Minimal bilateral neural foraminal narrowing was noted. Minimal sclerosis with about the articular facets. At L5-S1 central 2-3mm soft tissue disc bulge was noted without significant spinal canal narrowing or neural foraminal narrowing. Sclerosis demonstrated about the articular facets. The request for outpt Anterior Lumbar Interbody Fusion L2-3 L3-4, Lateral Approach with Posterior Lumbar Decompression (To Include bilateral facetectomies which may predispose the patient to Iatrogenic instability), Posterior lateral fusion and Pedicle screw instrumentation at L2-3 L3-4, 2 day inpatient stay 2258 22851 22612 22614 63047 63048 22840 20902x2 77002x2 38220x2 95937x2 is not medically necessary. The patient had neurological findings on most recent physical examination but there were no updated MRI demonstrating substantial pathology at L23 L34 that would support proposed procedures. There was no clinical documentation of any recent conservative treatment with last physical therapy documented in 2009. With the absence of updated imaging studies and clinical documentation of recent conservative failure of recent conservative treatment, surgical request for this patient is not medically established at this time. The request for inpatient stay is not medically necessary as it is predicated on initial surgical request. As this has not been found to be surgically necessary, additional requests are not necessary. At 130 PM CST I spoke per our case discussion he stated that the carrier is not allowing them to do any therapy so they are at a standstill. As far as getting surgery because, the imaging is over 2 years old but, the carrier won't do any more so. Pre-operative imaging is needed before surgery, we need updated imaging first so, they need to approve that. Based on the information obtained from our conversation, determination remains unchanged.

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

The previous adverse determinations are upheld. This patient on 6/16/2014 has complaints of "sharp and stabbing low back pain with radiation into the left lower extremity along the anterolateral thigh and calf, and constantly into the dorsum of the left foot with associated numbness and tingling in a similar distribution. He currently describes his pain level as a 6/10 on a visual analog scale with worsening symptomatology following prolonged sitting, standing, coughing, sneezing or Valsalva maneuver." These complaints are initially reported to have started in the February 2013 timeframe in his February 2014 note. The patient's history is that of hearing a pop in his back followed by severe left leg pain/weakness and numbness on 10/20/1994 after lifting at work. He had a laminectomy in 2008 by history at L4/5 but this is unclear on CT myelogram in May 2014. There needs to be some clarification of how the patient's present clinical complaints and CT myelogram findings relate to his prior work injury in xxxx. He appears to have disc herniations and stenosis at L2/3 and L3/4 which suggests these are new problems and not related to an injury in xxxx.

There has been no clear trial of lumbar injections or physical therapy to address these new complaints conservatively. The localization of the leg weakness and

pain to the left leg makes the option of left sided laminotomy and discectomy at L2/3 and L3/4 the most straight forward approach to his leg pain. There is no firm indication for L2/3 and L3/4 fusion articulated such as spondylolisthesis or instability or 2 previous discectomies at these levels. This patient has the worrisome traits of chronic pain, smoking and what appears to be total disability for greater than 6 months that make a fusion unlikely to be successful in returning this patient to functioning well. There is no recent MRI to exclude diffuse disc degeneration, which would make a 2 level fusion very unlikely to relieve his back pain, nor a discogram to confirm that the L2/3 and L3/4 discs reproduce the patient's symptoms. An EMG/NCV of his left lower extremity would be helpful to assess the acuity of these nerve complaints to assess his prognosis. For these many reasons, I agree with the denial of this anterior/posterior procedure with fusion and screws to address this patient's pain and weakness.

Per ODG:

Patient Selection Criteria for Lumbar Spinal Fusion:
For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (Andersson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. (Andersson, 2000) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.)
Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)
For average hospital LOS after criteria are met, see Hospital length of stay (LOS).

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)**