April 13, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar 5-51 PLIF, Inpatient Stay, LSO Lumbar Brace

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Neurological Surgery 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 a female that was injured on the job on XX/XX/XX while working in a warehouse and lifting a 75lb bag of horse feed. The claimant ended up falling backwards onto the floor.

XX/XX/XX: MRI Lumbar W and WO Contrast. Impression: 1. Postoperative changes of left sided laminectomies at L4-5 and L3-4 with posterior fusion hardware between the L3 and L5 levels. There are annular tears at the L3-4 and L4-5 levels and a shallow left paracentral disc protrusion at L3-4 results in mild mass effect on the left ventral thecal sac but there is no significant spinal canal stenosis or residual foraminal narrowing operative levels. 2. The most significant diseases is at T11-12 where there is a posterior/central disc extrusion with superior extension measuring 1.9 cm craniocaudal resulting in compression of the ventral spinal cord but incompletely assessed on the examination. Thoracic spine MRI suggested for further evaluation. 3. Degenerative disc disease changes at L5-S1 resulting in moderate bilateral foraminal narrowing left greater than right. Correlation with radicular symptoms is recommended. Degenerative facet hypertrophy at L2-3 resulting in slight anterolisthesis.

XX/XX/XX: MRI of the Lumbar spine WO contrast. Impression: 1. Postoperative changes with bilateral pediole screw and posterior stabilization rod constructs spanning L3 through L5. 2. Partially visualized is superiorly extending disc exclusion at T11-T12 with suspected moderate central spinal canal stenosis and contouring of the ventral spinal cord. Correlation with a dedicated thoracic spine MRI examination would be recommended for additional characterization. 3. Trace grade 1 anterolisthesis L2 on L3 above the fusion segment. 4. Inferiorly extending disc extrusion L6-S1 with mild anccroachment upon the bilateral subartiular recess and traversing S1 nerve root sleeve without neural impingement. Mild right and moderate severe left L5-S1 neural foraminal stenosis is also present.
XX/XX/XX: Follow up. HPI: claimant was seen for follow up on T11-T12 thoracic ESI on XX/XX/XX. She reports that the thoracic pain is much better. Her constant pain is gone and now she gets it only occasionally. She wants to repeat the injection. Pt has anew MRI on XX/XX/XX which shows a 9 mm disc extrusion at T11-12. Reported pain level 6/10 without medications. Claimant is currently working full time. Claimant has completed 2 months of PT. Surgery x 2 and medication but continues to have moderate to severe pain on a daily basis. Medications: Cholesylamine, Hydrocodone, Synthroid 150 mg.

XX/XX/XX: Examination. HPI: Claimant underwent a lumbar laminectomy in XXXX which did not help. Postop she used a walked fir quite some time. In XXXX she underwent L3-4 and L4-5 decompression and fusion and did well. She had very little pain until XXXX when she developed spontaneous onset of low back and bilateral leg pain. The leg pain has been worse than the low back pain. The claimant saw a pain management doctor who did some lumbar facet injections. Claimant rated her pain a 4-8/10 averaging 6/10. Claimant is currently working as an office manager for a dentist. Medications: Synthroid, Hydrocodone 10/325mg, Ibuprofen. Examination: low back is nontender to palpation. There is some tenderness to palpation over the left groin. Gait, heel and toe walking is normal. ROM of the lumbar spine reveals flexion 45 degrees, extension 10 degrees, and lateral bending 10 degrees to the left and to the right. Straight leg rising on the left at 45 degrees produces tingling in bottom of her left foot. Motor exam reveals 5/5 in lower extremity muscle groups. Sensory exam is intact to pinprick. Reflexes are 2+ and symmetric in the upper and lower extremities. Patrick’s test is negative bilaterally.

XX/XX/XX: CT Lumbar spine W Myelogram. Impression: Degenerative spondylitis within the lumbar spine predominantly at the levels of L2-3 and L5-S1. Significant neural foraminal stenosis is identified. Post-operative changes from posterior spinal fusion L3-L5 with intact instrumentation. Post-operative changes within the lumbar spine with intact instrumentation. No evidence for abnormal motion. Degenerative changes as discussed.

XX/XX/XX: Follow up. Impression: 1. partially calcified central disc protrusion at L5-S1. 2. 8mm left partially calcified T11-T12 disc herniation with cephalic migration with spinal cord impingement. 3. Low back and left leg pain. 4. Status post lumbar laminectomy in XXXX without improvement. 5. Status post L3-4, L4-5 decompression and fusion in XXXX with pedicle screws at L3-4 and L5 with cross link.

XX/XX/XX: Evaluation. Electro diagnostic Impression: 1. I find no electro diagnostic evidence of acute or chronic lumbosacral radiculopathy on bilateral testing. 2. I find no electro diagnostic evidence of peripheral polyneuropathy. The patient had normal nerve conduction studies of the lower extremities and normal needle EMG other than some decrease in inserional activity in the lumbosacral paraspinals, which is most likely due to previous surgeries.

XX/XX/XX: Follow up. Examination: Low back is nontender to palpation. There is some tenderness to palpation over the left groin. Gait, heel and toe walking is normal. ROM of the lumbar spine reveals flexion 45 degrees, extension 10 degrees and lateral bending 10 degrees to the left and to the right. Straight leg raising on the left at 45 degrees produces tingling in bottom of her left foot. Motor exam reveals 5/5 in lower extremity muscle groups. Sensory exam is intact to pinprick. Reflexes are 2+ and symmetric in the upper and lower extremities. Patrick’s test is negative bilaterally. Plan: Will await the findings of her selective nerve root block. EMG was negative however she has a XXXX EMG that was positive. Will continue to confirm the pain generator for L5-S1 selective nerve root block.

XX/XX/XX: C-spine CMP 6 views. Impression: Postoperative changes from ACDF without developing radiographic abnormalities.

XX/XX/XX: Follow up. In XXXX, she underwent an L3-L4 and L4-5 decompression and fusion XX and did well. She had very little pain until XXXX when she developed spontaneous onset of lower back and bilateral leg pain. The leg pain has been worse than lower back pain. She saw an orthopedic surgeon, who recommended surgery. The patient declined surgery. She then saw pain management and got treated with facet injections, which helped for
three months. She has had several of these in attempts to control the pain since XXXX. She more recently saw XX who repeated her lumbar facet injections. These helped temporarily. She denies any bowel or bladder problems. She has lower back pain on a daily basis. It is constant. She rates it at 4-8/10 averaging 6/10. It increased with twisting and sitting. She currently complains of lower back pain and left leg pain. She also has a known history of T11-12 disc herniation back as far as XXXX. EMG dated XX/XX/XX is negative. However, her previous EMG in XX/XXXX notes abnormal EMG of bilateral lower extremities showing positive evidence of right L5 lumbosacral radiculopathy. Lumbar spine x-rays revealed pedicle screws at L3-4 applied bilaterally with a cross bar. There are no cages. Lumbar myelogram dated XX/XX/XX I reviewed. AP views are unremarkable. Lateral views are too dilute. Post myelogram CT scan reveal partial calcified central L5-S1 disc bulging with slight caudal migration. There is L5-S1 disc space narrowing. There is vacuum phenomenon at L5-S1 disc. The disc measures 16 mm medial to lateral, 5mm anterior to posterior. It encroaches into the left lateral recess and some aspect of the left SI nerve root. There is foraminal extension and endplate osteophyte on the left with moderate to severe left L5-S1 foraminal stenosis. Thoracic myelogram dated XX/XX/XX was reviewed. AP views revealed a diminished swelling on the left at T11-12. Post myelogram CT scan reveals an 8mm A-P left T11-12 partially calcified disc herniation. The disc extends approximately 2cm. There is some mass effect on the left anterior aspect of the spinal cord. She returns today. She had a selective nerve root block on 5-S1 on Wednesday, XX/XX/XX. She had great results with this, 90% improvement in her lower back pain and left leg pain. This lasted for approximately four days. She was able to do more of her activities without pain. Recommendations: Pt is S/P a Thoracic ESI at T11-12 done XX/XX/XX/XX/XX. Pt states that her constant stabbing pain has returned. She is here to discuss surgical options. I will refill medication today. 2. The patient advised to continue with home based therapy. This is very important to be able to maintain ROM and lumbar spine strength and to avoid deconditioning. Patient need to participate in both active and passive rehab modalities.

XX/XX/XX: UR. Rationale for denial: After peer review of the medical information present and or discussion with a contracted Physician advisor and the medical provider, it has been determined that the health care service (s) requested does not meet established standards of the medical necessities.

XX/XX/XX: Letter. Examination: Lower back is nontender. There is some tenderness to palpation over the left groin. Gait, heel and toe walking is normal. ROM of the lumbar spine reveals flexion 45 degrees, extension 30 degrees and lateral bending 10 degrees to the left and to the right. Straight leg raising on the left at 45 degrees produces tingling in bottom of her left foot. Motor exam reveals 5/5 in lower extremity muscle groups. Sensory exam is intact to pinprick. Reflexes are 2+ and symmetric in the upper and lower extremities. Patrick’s test is negative bilaterally. Impression: 1. Partially calcified central disc protrusion L5-S1. 2. Low back and left leg pain. 3. Status post lumbar laminectomy in XXXX without improvement. 4. Status post L3-4, L4-5 decompression and fusion in XXXX with pedicle screws at L3, L4, and L5 with a cross-link. Recommendations: This patient is symptomatic from the L5-S1 level. She meets all the ODG guidelines Patient Selection Criteria for Lumbar Spinal Fusion L5-S1.

XX/XX/XX: UR. Rationale for denial: As requested, a second contracted physician who was not involved in the original non-certification has review the original information, supplemented by additional medical records submitted and or peer discussion with the treating provider. The second physician has upheld our original non-certification.

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

The previous determination has been upheld. This patient has no spondylolisthesis or documented instability at L5/S1 to warrant a fusion. The stenosis noted at L5/S1 may be factoring into her leg pain and may be amenable to lumbar decompression surgery only. Her back pain suggests a failed back surgery pattern that may be better addressed with spinal cord stimulator trial and assessment for psychological fitness for permanent implant. The present hardware does not have any loosening or fracture noted that warrants hardware removal. This patient needs to be considered for other treatment modalities other than L5/S1 fusion. Therefore, the request for Lumbar 5-5 PLIF, Inpatient Stay, LSO Lumbar Brace is non-certified.
ODG Guidelines:

**ODG Indications for Surgery™ -- Discectomy/laminectomy --**

Required symptoms/findings; imaging studies; & conservative treatments below:

I. **Symptoms/Findings** which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

A. L3 nerve root compression, requiring ONE of the following:
   1. Severe unilateral quadriceps weakness/mild atrophy
   2. Mild-to-moderate unilateral quadriceps weakness
   3. Unilateral hip/thigh/knee pain

B. L4 nerve root compression, requiring ONE of the following:
   1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
   2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
   3. Unilateral hip/thigh/knee/medial pain

C. L5 nerve root compression, requiring ONE of the following:
   1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
   2. Mild-to-moderate foot/toe/dorsiflexor weakness
   3. Unilateral hip/lateral thigh/knee pain

D. S1 nerve root compression, requiring ONE of the following:
   1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
   2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
   3. Unilateral buttock/posterior thigh/calf pain

   *(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)*

II. **Imaging Studies**, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

A. Nerve root compression (L3, L4, L5, or S1)
B. Lateral disc rupture
C. Lateral recess stenosis

   1. MR imaging
   2. CT scanning
   3. Myelography
   4. CT myelography & X-Ray

III. **Conservative Treatments**, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (>= 2 months)
B. Drug therapy, requiring at least ONE of the following:
   1. NSAID drug therapy
   2. Other analgesic therapy
   3. Muscle relaxants
   4. Epidural Steroid Injection (ESI)
C. Support provider referral, requiring at least ONE of the following (in order of priority):
   1. Physical therapy (teach home exercise/stretching)
   2. Manual therapy (chiropractor or massage therapist)
   3. Psychological screening that could affect surgical outcome

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)