Specialty Independent Review Organization

Date notice sent to all parties: 10/17/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an XX, possible fusion.

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 agrees with the previous adverse determination regarding the prospective medical necessity of an inpatient XX, possible fusion.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XXXX who sustained an industrial injury on XXXX. The mechanism of injury was not documented in the submitted medical records. XXXX underwent XX and interbody fusion with XX on XXXX. Records indicated that XXXX did well in the post-op period until XXXX when XXXX developed low back pain radiating into the anterior thighs. Social history was negative for XXXX.

The XXXX XX XX minor scoliosis XX desiccation at XX, and previous interbody fusion at XX additional bilateral bridging pedicle screws and laminectomy. There was moderate central canal XX, XX, and XX, and XX. There were post-operative XX without XX, and broad-based XX with XX narrowing. There was a XX.

The XXXX treating physician chart note documented an increase in XXXX XX pain radiating to the XX thigh with numbness. Physical exam documented XX and XX with XX leg raise. Medications were prescribed to include XXXX. The treatment plan recommended weight loss and moist heat. The XXXX treating physician telephone note indicated that the patient called in

and was finishing the steroids with no change. The diagnosis was documented as XX radiculopathy. An XX of the XX XX was ordered.

The XXXX XX XX XX documented XX, and stable to slight increase in the degree of XX compared to the XXXX study. Findings at the XX a 3XX and XX with increased XX.

The XXXX surgeon report cited complaints of grade 10/10 lower XX pain radiating to the groin and XX leg with associated numbness and tingling over the past month. XXXX was currently taking over-the-counter medications. XXXX had not had physical therapy or pain management for the current problem. XXXX was status post prior XX/XX laminectomy and fusion with pedicle screws and rods in XXXX. XXXX did well until XXXX. XXXX had an exacerbation of lower back and leg pain across the anterior thighs. This resolved with some therapy until XXXX when XXXX symptoms started returning with more severe pain. XXXX also complained of some bilateral knee pain, XX greater than right. XX XX exam documented generalized tenderness, well-healed incision, slightly decreased range of motion, XX/XX spinous process tenderness, paraspinal tenderness in the XX/XX region, and positive supine and seated straight leg raise on the XX. Lower extremity neurologic exam documented XX/XX XX quadriceps and tibialis anterior weakness, decreased XX XX and XX dermatomal sensation, and diminished 1+ and symmetrical bilateral lower extremity reflexes. XX was reviewed and showed disc degenerative above and below XXXX previous fusion site, with the XX/XX level having significant facet hypertrophy and moderate XX stenosis, XX greater than right. The diagnosis included XX/XX XX and stenosis causing radiculopathy, most likely from adjacent segment disease from previous fusion. XXXX had failed conservative treatment with exercises and anti-inflammatory medication. The treatment plan recommended XX/XX laminectomy and possible fusion if found to be unstable.

The XXXX utilization review determination indicated that the request for XX/XX laminectomy and possible fusion was denied. The rationale stated that there were no flexion/extension x-rays documenting XX XX instability, no XX evidence of nerve root impingement, and no electrodiagnostic studies showing any radiculopathy. Additionally, the records did not reflect lower levels of care, such as physical therapy, occupational therapy, chiropractic care, or corticosteroid injection.

The XXXX provider appeal letter indicated that the patient had low back pain radiating to the groin and XX leg with numbness and tingling. XXXX was currently taking over-the-counter medications to help with XXXX pain. Reconsideration of the denial decision was requested.

The XXXX utilization review determination indicated that the appeal request for XX/XX laminectomy and possible fusion was denied. The rationale stated that there was no clear imaging evidence of nerve root impingement, and no documentation of flexion/extension x-rays documenting XX XX instability. Additionally, the records did not reflect lower levels of case, such as a recent course of physical therapy, chiropractic treatment, or corticosteroid injections, and there was no indication that the patient had undergone psychological screening consistent with guidelines.

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

This patient presents with a XX-month history of increased low back pain radiating into the XX medial thigh with associated numbness and tingling. Clinical exam findings have documented sensory and motor deficits, diminished reflexes, and positive straight leg raise testing consistent with reported XX/XX XX and stenosis. XXXX has reportedly failed to improve with exercises and medications. XXXX is status post prior fusion at the XX/XX level. Under consideration is a request for XX/XX laminectomy and possible fusion. Guideline criteria have not been met. There is no clear imaging evidence of nerve root impingement at the XX/XX level or positive electrodiagnostic evidence for radiculopathy. There is no documentation of signs/symptoms of neurogenic claudication. There is imaging evidence of grade 1 XX/XX XX, but there is no documentation of flexion/extension x-rays demonstrating XX segmental instability or angular motion. There is no discussion supporting the need for wide decompression that would result in temporary intraoperative instability and necessitate fusion. There is no documentation of psychological screening consistent with guidelines. There is no documentation of a recent trial of physical therapy or manual therapy intervention, despite prior benefit with therapy. Additionally, the patient has been recommended for inpatient stay with no specific duration specified. Therefore, this request for inpatient XX/XX laminectomy and possible fusion is not medically necessary at this time.

The Official Disability Guidelines:
Recommend criteria for XX discectomy/laminectomy that include symptoms/findings that confirm the 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. 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, including activity modification, drug therapy, and support provider referral. Guidelines do not recommend XX fusion for patients with degenerative disc disease, disc herniation, XX stenosis without degenerative XX 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 XX, 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 15 degrees XX/XX through XX/XX, 20 degrees XX/XX, 25 degrees L5/S1. XX instability criteria includes XX inter-segmental translational movement of more than XX.XX mm. Pre-operative clinical surgical indications require completion of all physical therapy and manual therapy interventions, x-rays demonstrating XX instability and/or imaging demonstrating nerve root impingement correlated with symptoms and exam findings, XX fusion to be performed at 1 or XX 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. Guidelines recommend a best practice target length of stay of one day for XX laminectomy and 3 days for XX fusion.

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)