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Notice of Independent Review Decision

August 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cadaveric Allograft, Pedicle Screws 22633, 22634, 22015, 22840, 22841, 22851, 63012, 63030, 63035, 63047, 63048, 77003, 69990, 20931, 20938, 20975, 22325, 22558, 22585, 22612, 22614, 64493, 64494, Inpt Lumbar Laminectomy, Discectomy, Spinal Fusion, Interbody Cage

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

This physician 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 patient is a male who was injured at work.

12/06/2013: Progress Note. **HPI:** Pain from Lt lower back radiating to Lt scrotum, unable to walk, bend or lift. **Surgical History:** For GSW to Lt neck. **Medications:** Flexeril, Tramadol, Etodolac **Examination:** Abdomen: Lt groin with palpable small LIH, severe Lt scrotal tenderness, no erythema or edema, no scrotal sac. Back Severe Lt lumbosacral tenderness, positive sciatic pull, severe low lumbar muscle spasm. **Assessment:** R/O Herniated disc **Plan:** MRI Lumbosacral Spine Vicodin

12/09/2013: MRI Lumbar WO/W. **Impression:** 1. At L5-S1 there is moderately advanced disc degeneration, diffuse 4mm-5mm central and left lateralizing broad-

based spondylitic protrusion with impingement of emanating left L5 nerve root. 2. At L4-5 there is diffuse 3-4 mm posterior spondylitic protrusion with borderline central canal stenosis. There is diffuse bilateral foraminal and lateral recess stenosis, relatively symmetric. 3. At L3-4 there is diffuse 2-3 mm posterior protrusion, eccentric to the right with impingement of distal right emanating L3 nerve root in the distal foramen. 4. Multilevel facet arthrosis. 5. No significant enhancement seen following contrast administration.

12/17/2013: Evaluation. **Subjective:** The patient is here for a follow up on left hip and groin area. Also lower back. He states that pain level is 8/10. Lumbar Spine: Patient states that overall the symptoms have remained the same. Pain level has remained the same. **Exam:** Lumbar Spine: Full ROM, inspection, no obvious deformities. Lower extremities. Sensation normal. Muscle strength normal. ROM tender in groin. X-rays: Lumbar spine: 4 views-negative for fracture or dislocation **Diagnosis:** Left Lumbar sprain 817.20, Left intervertebral disc disorder with myelopathy lumbar region 722.73, Left abdominal pain left lower quadrant (groin) **Recommendations:** 1. No PT at this time 2. No medication required. 3. Referral to ortho spine as states was told by surgeon that he had pinhead nerve in back after MRI done and reviewed. 4. Will do our own referral to neurosurgeon 5. Referral to the Neurosurgeon

01/23/2014: Pain Management Initial Evaluation. **History:** The patient is seen in consultation at the request. This is a gentleman with a chief complaint of left-sided low back pain with radiation down into the left lower extremity rated at a VAS score up to 9/10. The patient describes the pain sharp, shooting, stabbing, aching, and burning occasionally with numbness and tingling in the same distribution down at the bottom of the left foot. The patient also incurred a left groin hernia, which he plans to undergo surgery next week. The patient has been under the care and supervision undergoing PT/medication management involving ODG guidelines for at least six weeks. The patient was evaluated by a neurosurgeon, who is recommending injections. Due to persistence of symptoms, aggravated by walking, bending, twisting, and standing for prolonged periods of time, the patient is here for further evaluation and treatment options. **Physical Examination:** The patient is 5 feet 11 inches, 215 pounds. He is ambulating with an antalgic gait favoring the left lower extremity. Focus examination of the lumbosacral spine reveals tenderness in the lumbar spinous process at L4-L5 and L5-S1 levels. Lumbar paraspinal muscles are tender to palpation bilaterally, diffusely localized throughout. ROM in flexion is 45° and extension 10° with decreased left lateral bending and rotational maneuvers. Straight leg raise is positive on the left in the sitting and supine position 80-90° and negative on the right. Motor strength of the lower extremities is diminished on the left as compared to the right, specifically involving the muscle groups, extensor digitorum longus and extensor hallucis longus. Reflexes of the lower extremities, left ankle jerk 1+/4, otherwise 2+/4 throughout. Heel walk is appropriate. Toe walk is impaired secondary to low back pain. Sensory examination of the lower extremities is decreased to light touch in left L5 dermatomal distribution. **Impression:** 1. Lumbar discogenic pain with radiation down the left lower extremity. 2. Lumbar myofascial pain syndrome 3.

Failed conservative treatment. **Plan:** 1. Discussed with the patient that I would like to proceed with a left L5 transforaminal ESI x1. Efficacy of the procedure will be evaluated prior to proceeding with further interventional pain management. IV sedation is required for this patient subsequent to history of extreme needle phobia. 2. Independent physical rehabilitative activity should be continued in concert with recommended injections in order to optimize the patient's outcome. 4. In terms of medication, I have provided Lyrica 75 mg#30 one p.o. q.h.s nerve pain. 4. The patient is to return to clinic in one month for follow-up.

01/30/2014: Operative Report. **Postoperative Diagnosis:** Left inguinal hernia
Procedure performed: Left inguinal hernia repair.

02/06/2014: Progress Note. **HPI:** Sharp pain on rt scrotum, worse when coughing, sneezing, or lifting. **Examination:** Abdomen: Obese, left inguinal hernia incision clean and healing well, tender at base of the scrotum at external inguinal ring with pain radiating to lt scrotum. Testicle not tender. **Assessment:** Status Post-V45.89 Pain in scrotum S/P LIH repair. **Treatment:** Pt with pain along lt genitofemoral nerve. Rec nerve block. Will await for possible approval. Rx Norco 7,5. **Follow up:** 2 weeks

02/12/2014: CT lumbar spine without contrast interpreted. **Impression:** 1. Spondylosis/osteoarthritis 2. Degenerative disc disease 3. Spinal stenosis at L5-S1. 4. Anterolateral and subarticular recess narrowing with nerve root impingement.

02/18/2014: Progress Note. **HPI:** Pt developed increasing swelling and pain on lt testicle over last week. He was seen in ER last night, had USN Lt testicle. Was given Morphine and Rx of Vicodin. **Assessment:** 1. Status Post, Acute Lt epididymitis, S/P LIH repair, Lt Groin nerve neuritis, constipation **Plan:** Ice pack, Cipro, stool softener **Follow Up:** 1 week

02/27/2014: Progress Note. **HPI:** Cont with sharp pain Rt groin below incision and radiating down to the scrotal area Rt testicle. **ROS:** Genito-Urinary: Denies dysuria, urinary urgency, increased, frequency, hematuria. Musculoskeletal: Muscle aches, back pain. Neurology: Denies numbness, tingling of extremities, denies lightheadedness, denies loss of sensation. **Medications:** Flexeril, Tramadol, Etodolac **Assessment:** Acute Neuritis lt Ilioinguinal Nerve, S/P LIH Repair **Procedures:** Nerve Block Localization by triggerpoint, skin prepped with betadine solution, injected Marcaine 0.75%, Decadron. Results significant improvement of pain. **Follow Up:** 2 weeks

03/14/2014: Progress Note. **HPI:** Pt felt without pain for 2 days, now returns with pain on Lt scrotal area and below incision, walking better, less pain when bending or walking. **Examination:** Left Inguinal hernia incision healing well, tender toward the Femoro cutaneous nerve. Tender below incision at Genitocutaneous nerve, much less tender than before. **Assessment:** Neuritic pain lt groin, S/P LIH repair **Plan:** 1 Rec repeat nerve block, Return when approved.

05/12/2014: Progress Note, hand written and hard to read. **HPI:** Still has low back pain. ESI was no help. **Examination:** Lumbar decreased ROM with pain. Dorsiflexion 4+/5. **Plan:** Schedule Lumbar fusion.

05/20/2014: UR. Rational for Denial: The request for Inpt Lumbar Laminectomy, Discectomy, Spinal Fusion, Interbody Cage-Cadaveric Allograft, Pedicle Screws 22633, 22634, 22015, 22840, 22841, 22851, 63012, 63030, 63035, 63047, 63048, 77003, 69990, 20931, 20938, 20975, 22325, 22558, 22585, 22612, 22612, 22614, 64493, 64494 is not recommended as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The patient is status post inguinal hernia repair. The patient also reported complaints of low back pain radiating into the left lower extremity to the toes with associated weakness. The patient previously utilized a lumbar support orthosis with some help. The patient reported no benefit from anti-inflammatories. MRI of the lumbar spine on 12/09/13 noted 2-3 mm disc protrusion at L3-4 and 3-4mm disc protrusion at L4-5 with borderline central canal stenosis and diffuse bilateral neural foraminal and lateral recess stenosis at L4-5. At L3-4 there was some eccentricity of the disc protrusion to the right impinging the right emanating L3 nerve root. At L5-S1 there was moderately advanced degenerative disc disease with a 4-5mm central to left lateralizing disc protrusion impinging the left L5 nerve root. Neurosurgical consult from 1/10/14 noted mild weakness in the left lower extremity due to pain. 2+ and symmetric reflexes were present. No sensory deficit was identified. There was tenderness to palpation in the lumbar spine primarily over the L4 L5-S1 levels. Mild weakness was present to the left at the quadriceps. CT of the lumbar spine on 2/12/14 again noted a disc osteophyte complex at L5-S1 with facet hypertrophy contributing to mild canal and lateral recess stenosis with some degree of impingement on the L5 and S1 exiting nerve roots. There was a progress report from 5/12/14 which was handwritten. It appears the patient had no improvement with epidural steroid injections and continued to have limited ROM in the lumbar spine due to pain. It appears there was mild weakness on dorsiflexion. Surgical request is unclear in regards to what level is being considered for surgical intervention. Imaging does not identify any evidence of motion segment instability severe spondylolisthesis or motion or complete disc space collapse which would require lumbar fusion procedures. Imaging also does not identify any substantial contributing facet disease at any level that would reasonably require extensive resection contributing to iatrogenic instability which would then require fusion for stabilization. The clinical documentation does not discuss exhaustion of physical therapy as recommended by guidelines. There was also no preoperative psychological consult available for review ruling out any confounding issues that may possibly impact post-operative recovery. Furthermore there is limited evidence within the clinical literature supporting the combined use of surgical procedures for the lumbar spine such as decompression and fusion in association with facet injections. Facet injections are considered a conservative invasive procedure that should be exhausted prior to consideration for further surgical intervention. There was insufficient rationale supporting the combined use of fusion and decompression procedures and facet

injections. Without additional clinical information supporting the surgical requests this reviewer would not recommend certification at this time.

06/10/2014: Letter of consideration. "Neurological exam reveals that the patient walks with an obvious limp. His range of motion in low back is significantly reduced due to mechanical back pain. He also has significant weakness in the left foot. " "In summary, the patient suffered a work-related accident leading to a sizable disc herniation and disc collapse, which now is causing significant nerve compression with foraminal stenosis due to the loss in interspace height between L5 and S1. The patient has failed nonsurgical treatments for five months, as of the last visit and now over seven months as of the date of this dictation, and given his unremitting pain despite nonsurgical treatment combined with his evidence of neurologic damage, I feel that it is medically indicated for the patient to undergo spine surgery to fix his problem." " In particular, I recommend a lumbar laminectomy, facetectomy to achieve neurologic decompression. The facetectomy that is required to decompress the foraminal stenosis will thereby produce spinal stability. As such, the laminectomy and facetectomy will need to be supplemented with spinal fusion and pedicle screw fixation. Restoration of interspace height will be performed with an interbody cage. All this will be done through the posterior approach in one surgery.

07/02/2014: UR. Rational for Denial: The patient is a male who sustained a lifting injury on xx/xx/xx. The patient is diagnosed with disc osteophyte complex at L5-S1 with facet hypertrophy contributing to mild canal and lateral recess stenosis with some degree of impingement on the L5 and S1 exiting nerve roots. An appeal request is made for the in-patient lumbar laminectomy, discectomy, spinal fusion, interbody cage-cadaveric allograft and pedicle screws (22633, 22634, 22015, 22840, 22841, 22851, 63012, 63030, 63035, 63047, 63048, 77003, 69990, 20931, 20938, 20975, 22325, 22558, 22585, 22612, 22612, 22614, 64493, 64494). The previous request was denied because surgical request is unclear in regards to what level is being considered for surgical intervention. Imaging does not identify any evidence of motion segment instability severe spondylolisthesis or motion or complete disc space collapse which would require lumbar fusion procedures. Imaging also does not identify any substantial contributing facet disease at any level that would reasonably require extensive resection contributing to iatrogenic instability which would then require fusion for stabilization. The clinical documentation does not discuss exhaustion of physical therapy as recommended by guidelines. There was also no pre-operative psychological consult available for review ruling out any confounding issues that may possibly impact post-operative recovery. Furthermore there is limited evidence within the clinical literature supporting the combined use of surgical procedures for the lumbar spine such as decompression and fusion in association with facet injections. Facet injections are considered a conservative invasive procedure that should be exhausted prior to consideration for further surgical intervention. There was insufficient rationale supporting the combined use of fusion and decompression procedures and facet injections. MRI of the lumbar spine dated 12/09/2013 noted 2-3mm disc protrusion at L3-4 and 3-4mm disc

protrusion at L4-5. At L3-4 there was some eccentricity of the disc protrusion to the right impinging the right emanating L3 nerve root. At L5-S1 there was moderately advanced degenerative disc disease with a 4-5mm central to left lateralizing disc protrusion impinging the left L5 nerve root. CT of the lumbar spine dated 2/12/14 noted a disc osteophyte complex at L5-S1 with facet hypertrophy contributing to mild canal and lateral recess stenosis with some degree of impingement on the L5 and S1 exiting nerve roots. The updated medicals include a previous UR determination dated 5/20/14 and a medical report dated 6/10/14 which states that the patient has severe low back pain that radiates down the left lower extremity and groin. He has also noted numbness and weakness in the left leg and foot. It was noted that the patient has undergone bracing, anti-inflammatory medications, steroid treatment orally, and epidural steroid treatments. However, the patient continues to suffer severe debilitation pain. Neurological exam reveals that the patient walks with an obvious limp. His ROM in low back is significantly reduced due to mechanical back pain. He also has significant weakness in the left foot. Imaging of the lumbar spine showed a disc protrusion at the L5-S1 level with significant loss of disc height. This loss of disc height has led to significant foraminal stenosis, especially on the left side at L5-S1. The patient has failed nonsurgical treatments. Given his unremitting pain despite nonsurgical treatment combined with his evidence of neurologic damage, the provider feels that it is medically indicated for the patient to undergo spine surgery to fix his problem. The provider recommended a lumbar laminectomy, facetectomy to achieve neurologic decompression. The facetectomy that is required to decompress the foraminal stenosis will thereby produce spinal stability. As such, the laminectomy and facetectomy will need to be supplemented with spinal fusion and pedicle screw fixation. Restoration of interspace height will be performed with an interbody cage. All this will be done through the posterior approach in one surgery. It was noted that the patient is a good candidate, and medically indicated to undergo lumbar fusion surgery at the L5-S1 level to treat his unremitting symptoms. Although the patient has persistent pain and symptoms despite conservative care, the psychological evaluation for the procedure was still not submitted for review. CPT 64493 and 64494 pertains to injection of paravertebral facet joint of the lumbar spine. The clear rationale for supporting the combined use of fusion and decompression procedures and facet injections was still not elaborated. In agreement with the previous determination, the medical necessity of the request has not been established.

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 had a work injury in xx/xxxx. The patient had a left groin hernia, back and leg pain after the incident. He had the hernia repaired in Jan 2014 and has had some residual groin pain. He had some injections for his back and leg pain without clear relief. His Lumbar MRI in December 2013 showed left sided disc bulge at L5/S1 and CT in Feb 2014 shows stenosis at L5/S1 with degenerative disc disease at unspecified levels without spondylolysis or lithesis. The patient's response to physical therapy is not

well documented. There is no psychological evaluation documented or any EMG/NCV to assess the left leg symptoms. Given the MRI findings in December 2013, the only surgery that would appear indicated would be a left L5/S1 microdiscectomy (63030,69990), if the patient is felt to have a persistent foot drop with radicular pain, which was not documented in the records. In the absence of instability, a discogram localizing his back pain only to L5/S1, and a psychological workup excluding problems that need intervention, no lumbar fusion is felt to be supported. A 4-6 week trial of physical therapy may help with the patient's back pain and range of motion and also needs to be documented before a lumbar fusion can be considered. For these reasons, Cadaveric Allograft, Pedicle Screws 22633, 22634, 22015, 22840, 22841, 22851, 63012, 63030, 63035, 63047, 63048, 77003, 69990, 20931, 20938, 20975, 22325, 22558, 22585, 22612, 22614, 64493, 64494, Inpt Lumbar Laminectomy, Discectomy, Spinal Fusion, Interbody Cage is not medically necessary at this time and should be denied.

Per ODG:

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

Diagnostic imaging modalities, requiring ONE of the following:

- 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 (\geq 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
 4. [Back school](#) (Fisher, 2004)

For average hospital LOS after criteria are met, see [Hospital length of stay](#) (LOS).

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](#))

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)**